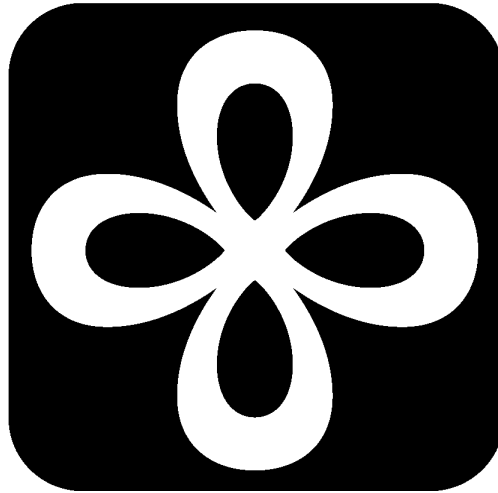


**STATE OF IOWA  
DEPARTMENT OF HUMAN SERVICES**

# **MEDICAID**



## **Provider Manual**

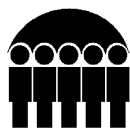
**Home Health Services**



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## I. CONDITIONS OF PARTICIPATION

Home health agencies are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

Medicare-certified agencies are eligible to provide the following Medicaid services:

- ◆ Home health agency intermittent services. Services are for patients of all ages, but are limited by the intermittent policy. See Section III, **HOME HEALTH AGENCY INTERMITTENT SERVICES**.
- ◆ Private-duty nursing and personal care services under the early and periodic screening, diagnosis, and treatment authority. These services are only for patients aged 20 and under and are covered when they are medically necessary, appropriate, and exceed intermittent policy. See Section IV, **PRIVATE-DUTY NURSING AND PERSONAL CARE SERVICES**.

While both groups may be provided by a Medicare-certified agency, the Medicaid guidelines for each group differ; e.g., number of available hours, billing mechanism, prior authorization. Each group is defined in a separate section of the manual. Be sure that you are following the guidelines for the service you are providing.

## II. TREATMENT PLAN

Service must be authorized by a physician, as evidenced by the physician's signature and date on a plan of treatment within the certified period. For a home health service to be payable, a plan of treatment must be completed before the start of care and reviewed at a minimum of every 62 days thereafter.

The home health agency is responsible for coordination of care provided to a patient. As a result, the plan of care shall reflect all services provided for the Medicaid recipient, regardless of whether the services are personally provided by the home health agency.

For example, all home health agency skilled services, home health aide services, in-home health-related care program services, and waiver services shall be reflected in one treatment plan. To assist in the review process, the plan shall note what is being proposed for each payer.



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We encourage you to use Medicare HCFA 485, 486, or 487 forms to present the plan of care. If you use other forms, they must contain the information noted in this section.

When more than one plan of care covers a calendar billing month, submit all pertinent care plans with the UB-92 claim form.

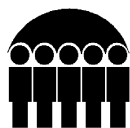
The following sections describe:

- ◆ General requirements for all home health agency treatment plans.
- ◆ Additional requirements for plans that include rehabilitation services, home health aide services, or teaching, training or counseling services.

## A. General Requirements

The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- ◆ The patient's medical condition, as reflected by the following information, if applicable:
  - Dates of prior hospitalization.
  - Dates of prior surgery.
  - Date last seen by a physician.
  - Diagnoses for which treatment is being rendered.
  - Dates of onset of these diagnoses.
  - Prognosis.
  - Functional limitations.
  - Vital signs reading.
  - Date of last episode of instability.
  - Date of last episode of acute recurrence of illness or symptoms.
  - Medications.
- ◆ Type of service required.
- ◆ Type of service to be rendered.
- ◆ Place of service.
- ◆ Discipline of the person providing the service.
- ◆ Treatment modalities being used.



- ◆ Frequency of the services.
- ◆ Assistance devices to be used.
- ◆ Medical supplies to be furnished.
- ◆ Certification period (no more than 62 days).
- ◆ Date home health services initiated.
- ◆ The date of onset of the teaching, training, or counseling provided by the home health agency.
- ◆ Progress of the patient in response to treatment.
- ◆ Estimated date of discharge from the hospital or home health agency services, if applicable.
- ◆ Physician's signature and date. The date of signature shall be within the certification period.

## **B. Rehabilitation Services**


For physical, speech, or occupational therapy, the treatment plan shall additionally be completed every 30 days, indicate the type of service required and include:

- ◆ Measurable goals.
- ◆ Modalities of treatment.
- ◆ Date of onset of conditions being treated.
- ◆ Restorative potential.
- ◆ Progress notes reflecting progress toward measurable goals.

## **C. Home Health Aide Services**

For home health aide services, the treatment plan shall additionally include:

- ◆ Frequency of visits.
- ◆ Number of hours per visit.
- ◆ Living arrangement for patient (lives alone, with family, status of caregiver, etc.).
- ◆ Services rendered.

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## **D. Teaching, Training, and Counseling**

For teaching, training, and counseling, the treatment plan shall additionally include:

- ◆ To whom services were provided (patient, family member, etc.).
- ◆ Prior teaching, training, or counseling provided.
- ◆ Medical necessity for the rendered service.
- ◆ Specific services and goals.
- ◆ Date of onset of teaching, training, or counseling.
- ◆ Frequency of services.
- ◆ Progress of patient in response to treatment.
- ◆ Estimated length of time these services will be needed.

## **III. HOME HEALTH AGENCY INTERMITTENT SERVICES**

Home health agency intermittent services are an appropriate alternative to unnecessary institutionalization. The services are provided in the patient's home by a registered nurse, a licensed practical nurse, a home health aide, a speech therapist, a physical therapist, an occupational therapist, or a social worker employed by the agency.

These services are available for patients of all ages, but are limited to those visits that meet the definition of "intermittent." Generally, "intermittent service" means services for a patient who has a medically predictable recurring need that does not exceed two to three visits per week for two to three hours at a time.

The number of hours of intermittent services shall be reasonable and appropriate to meet an established medical need of the patient that cannot be met by a family member, significant other, friend, or neighbor. Home health agency intermittent services are covered only when provided in the patient's residence.

Components of intermittent services are specifically addressed in the component sections. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability. Submit documentation with each claim to support the need for the services being provided.



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Unlike the Medicare program, patients need not first require “skilled” care before they are entitled to home health aide services. For example, if a patient requires only home health aide services, the patient is entitled to these services under the Medicaid program without respect to the need for skilled services.

The patient need not be homebound to be eligible for home health agency intermittent services. However, the services provided by a home health agency are covered only when provided in the recipient’s residence.

Payment will be made both for restorative service, as in the Medicare program, and also for maintenance services. Essentially, “maintenance service” means service to a patient whose condition is stabilized and who requires observation by a nurse of conditions defined by the physician as indicating a possible deterioration of health status. This includes patients with long-term illnesses whose condition is stable rather than post-hospital.

Payment may be made for teaching, training, and counseling in the provision of health care services.

When the need for services exceeds the intermittent guidelines, a request for an exception to policy may be submitted in writing, by fax (515-281-4597) or by mailing to the:

Appeals Section  
Department of Human Services  
1305 E Walnut, 5th Floor  
Des Moines, Iowa 50319-0114

The request should include:

- ◆ A cover letter.
- ◆ A current plan of care.
- ◆ At least four weeks notes for each service requested.
- ◆ A breakdown of the direct costs of providing services.
- ◆ A copy of the agency’s mileage reimbursement policy (when mileage reimbursement is included in the cost breakdown).



The cost breakdown must include:

- ◆ The salaries or the range or average salary for each type of care requested.
- ◆ Fringe benefits paid for each category of caregiver identifying each benefit paid.
- ◆ The actual amount paid for each benefit or the percent of salary for each benefit.
- ◆ The number of miles driven to provide care.

All home health services provided during each month for which an exception to policy is approved must be included in and billed under the exception to policy. (See **Basis of Payment for Intermittent Services** for instructions on how to bill services under an exception to policy.)

## A. Skilled Nursing Care

“Skilled nursing” services performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Services that can safely be performed by the patient or by an unskilled person who has received the proper training or instruction and services provided when there is no one else to perform the services are not considered “skilled nursing services.”

Skilled nursing services are available only on an intermittent basis. For skilled nursing, “intermittent services” are defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end.

Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end are covered for up to three weeks.

Coverage of additional daily visits beyond that initial anticipated timeframe may be appropriate for a short period of time, based on the medical necessity of service. Submit medical documentation justifying the need for continued visits, including the physician’s estimate of the length of time that they will be necessary.

Daily skilled nursing visits or multiple daily skilled nursing visits for wound care or insulin injections are covered when ordered by a physician and included in the plan of care.



When daily skilled nursing visits are ordered for other than wound care or insulin injections for an indefinite period of time (daily without a stated end date) and designated as daily skilled nursing care, they do not meet the intermittent definition and will be denied.

At the time of recertification, evaluate the care rendered to the patient as to whether it is reasonable and necessary. Training and teaching can rarely be justified after the first certification.

Skilled nursing services are evaluated based on the complexity of the service and condition of the patient. Refer to Medicare Intermediary Manual, Section 3118.1 and the Iowa Nurse Practice Act to determine what is considered to be a skilled nursing service.

**Note:** Private-duty nursing is not a covered service for patients aged 21 and over.

## **B. Home Health Aide Services**

“Home health aide services” are unskilled services that are covered if the following conditions are met:

- ◆ The service, the frequency, and the duration are stated in a written plan of treatment established by a physician. You are encouraged to collaborate with the patient or, in the case of a child, with the child’s caregiver in the development and implementation of the plan of treatment.
- ◆ The patient requires personal care services as determined by a registered nurse or other appropriate therapist.
- ◆ The services are given under the supervision of a registered nurse, a physical, speech, or an occupational therapist who assigns the aide who will provide the care and makes supervisory visits. See Section III, Item J, **Supervisory Visits**.
- ◆ Services are provided on an intermittent basis. “Intermittent basis” is defined as services that are usually two to three times a week for two to three hours at a time.



Service provided four to seven days per week, not to exceed 28 hours per week, are allowed as intermittent services when ordered by a physician and included in a plan of care. Increased services may also be allowed as intermittent services when medically necessary and provided due to unusual circumstances on a short-term basis of two to three weeks. Document the need for the excessive time required.

Home health aide daily care may be provided for patients employed or attending school whose disabling conditions (e.g., quadriplegia) require them to be assisted with morning and evening activities of daily living in order to support their independent living.

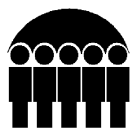
“Personal care services” include the activities of daily living, e.g., helping the recipient to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the patient in necessary self-help skills.

When the primary need of the patient for home health aide services is for personal care, the aide may perform certain household services to prevent or postpone the patient’s institutionalization. Examples of household services are:

- ◆ Changing the patient’s bed.
- ◆ Light meal preparation.
- ◆ Light cleaning.
- ◆ Laundering essential to the comfort and cleanliness of the patient.
- ◆ Rearrangements to ensure that the patient has and can safely reach necessary supplies or medications.

If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service.

Domestic or housekeeping services that are not related to patient care are not a covered service if personal care is not rendered during the visit.



## C. High-Risk Maternity or Child Health Care

The intent of home health services to maternity patients and children is to provide services when the patients are unable to receive the care outside their home and require home health care due to a high risk factor.

Routine prenatal, postpartum, or child health care for Medicaid recipients is a covered service in a physician's office or clinic. Therefore, Medicaid does not cover it when provided by a home health agency.

Payment is approved for care of high-risk patients when identified as such in the comment section of the billing form. In these cases, the treatment plan must indicate:

- ◆ The potential risk factors.
- ◆ The medical factor or symptom that verifies that the woman or child is at risk.
- ◆ The reason the patient is unable to obtain care outside the home.
- ◆ The medically related tasks of the home health agency.

If you are assisting the family to cope with a socioeconomic and medical problem, the treatment plan should indicate the involvement of the local Department of Human Services office.

The plan shall also document that you have agreed that in the best interest of the child, your services are needed to supplement the intervention of a social worker. For example, if a child has suffered abuse or neglect, the family may need intervention from a home health agency in addition to the county Department of Human Services.

The following list of potential high risk factors may indicate a need for home health services to maternity patients or children. A single risk factor is not sufficient information to allow reimbursement for home health agency services. Submit documentation to show:

- ◆ Evidence of the diagnosis.
- ◆ The specific services and goals.
- ◆ The medical necessity for the services to be rendered.



## 1. Prenatal Patients

Potential high risk factors for pregnant women include:

- ◆ Age 16 or under.
- ◆ First pregnancy for a woman aged 35 or over.
- ◆ Previous history of prenatal complications (fetal death, eclampsia, Cesarean section delivery, psychosis, diabetes).
- ◆ Current prenatal problems, such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol misuse.
- ◆ Sociocultural or ethnic problems, such as language barriers, lack of family support, insufficient dietary practices, history of victimization (child abuse or neglect), or single mothers.
- ◆ Pre-existing handicaps, such as sensory deficits or mental or physical handicaps.
- ◆ History of infant problems, such as premature birth, congenital anomalies, or sudden infant death.
- ◆ Second pregnancy in 12 months.
- ◆ Death of a close family member or significant other within previous year.

## 2. Postpartum Maternity Patients

Potential high risk factors for postpartum women include:

- ◆ Age 16 or under.
- ◆ First pregnancy for a woman aged 35 or over.
- ◆ Major postpartum complications, such as severe hemorrhage, eclampsia, or Cesarean section delivery.
- ◆ Pre-existing mental or physical disabilities, such as deafness, blindness, hemiplegia, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or mental retardation.
- ◆ Drug or alcohol abuse.



- ◆ Symptoms of postpartum psychosis.
- ◆ Special sociocultural or ethnic problems, such as lack of job, family problems, single mother, lack of support system, history of child abuse or neglect.
- ◆ Demonstrated disturbance in maternal and infant bonding.
- ◆ Discharge or release from hospital against medical advice before 30 hours postpartum.
- ◆ Insufficient antepartum care by history.
- ◆ Multiple births.
- ◆ Nonhospital delivery.

### 3. Newborns

Potential high risk factors for newborns include:

- ◆ Birth weight 5 pounds or under or over 10 pounds.
- ◆ History of severe respiratory distress.
- ◆ Major congenital anomalies as neonatal complications which necessitate planning for long-term follow-up, such as post-surgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
- ◆ Disabling birth injuries.
- ◆ Extended hospitalization and separation from other family members.
- ◆ Genetic disorders such as Down's syndrome and phenylketonuria, or other metabolic conditions that may lead to mental retardation.
- ◆ Noted parental rejection or indifference toward the baby, such as never visiting or calling about the baby's condition during the baby's extended stay.
- ◆ Family sociocultural or ethnic problems, such as low education level or lack of knowledge of child care.
- ◆ Discharge or release against medical advice before 36 hours of age.
- ◆ Nutrition or feeding problems.



#### 4. Preschool or School-Aged Children

Potential high risk factors for preschool or school-aged children include:

- ◆ Child or sibling victim of child abuse or neglect (services necessary to assist to remain in or return to family home, if possible).
- ◆ Mental retardation or physical disabilities necessitating long-term follow-up or major readjustments in family life style.
- ◆ Failure to complete basic series of immunizations by 18 months, or boosters by 6 years.
- ◆ Chronic illness, such as asthma, cardiac, respiratory or renal diseases, diabetes, cystic fibrosis, or muscular dystrophy.
- ◆ Malignancies, such as leukemia or carcinoma.
- ◆ Severe injuries necessitating treatment or rehabilitation.
- ◆ Disruption in family or peer relationships.
- ◆ Suspected developmental delay.
- ◆ Nutritional deficiencies.

#### D. Immunizations

Providers may provide immunizations when covered under the Vaccines for Children Program (VFC). Vaccines available through the VFC program are:

- 90702 Diphtheria and tetanus toxoids (DT) vaccine
- 90700 Diphtheria, tetanus toxoids, and acellular pertussis (DTAP) vaccine
- 90701 Diphtheria, tetanus toxoids, and pertussis (DTP), active vaccine
- 90720 Diphtheria, tetanus toxoids, and pertussis (DTP) and hemophilus influenza B (HIB) vaccine
- 90723 Diphtheria, tetanus toxoids and acellular pertussis, (DTAP) Hepatitis B, poliovirus (IPV) vaccine
- 90721 Diphtheria, tetanus toxoids and acellular pertussis, (DTAP)hemophilus influenza B (Hib) vaccine




90645	Hemophilus influenza B (Hib) HbOC conjugate (4 dose schedule)
90646	Hemophilus influenza B (Hib) PRP-D conjugate (booster only)
90647	Hemophilus influenza B (Hib) PRP-OMP conjugate (3 dose schedule)
90648	Hemophilus influenza B (Hib) PRP-T conjugate (4 dose schedule)
90744	Hepatitis B vaccine, pediatric/adolescent dosage
90746	Hepatitis B vaccine, adult dosage
90748	Hepatitis B and Hemophilus influenza B (HepB-Hib) vaccine
90743	Hepatitis B vaccine; adolescent
90657	Influenza vaccine, 6-35 months
90658	Influenza vaccine, 3 yrs. and older
90707	Measles, mumps, and rubella virus vaccine (MMR), live
90669	Pneumococcal conjugate, children under 5
90713	Poliovirus vaccine (IPV)
90718	Tetanus and diphtheria toxoids absorbed, for adult use (TD)
90716	Varicella vaccine

Bill code 90471 and 90472 for vaccine administration in addition to the CPT code.  
For VFC vaccine, the charges in field 47 should be "0."

## E. Medical Social Services

Payment will be made for medical social work services when:

- ◆ Services are provided in the consumer's home;
- ◆ The problems are not responding to medical treatment;
- ◆ There does not appear to be a medical reason for the lack of response; and
- ◆ The services meet **all** of the following conditions:
  - They are reasonable and necessary to the treatment of the patient's illness or injury.
  - They contribute meaningfully to the treatment of the patient's condition.
  - They are under the direction of a physician.
  - They address social problems impeding the patient's recovery.
  - They are given by or under the supervision of a qualified medical or psychiatric social worker.

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Any medical social services directed toward minimizing the problems an illness may create for the patient and family (such as encouraging them to air their concerns and providing them with reassurance) are not considered reasonable and necessary to the treatment of a patient's illness or injury.

## **F. Medical Supplies and Equipment**

Supplies should be incidental to the patient's care, such as syringes for Prolixin injections. Home health agencies are limited to supplies and equipment of no more than \$15 per month. When random postpayment review identifies supplies billed in excess of \$15 per month, the overpayment will be recouped.

Dressings, durable medical equipment and other supplies shall be obtained from a medical equipment dealer or pharmacy. (Special consideration may be given to unusual circumstances, such as when a pharmacy or medical equipment dealer is not available in the patient's community.)

If you choose to provide durable medical supplies and equipment in excess of the \$15 per month limit, you must enroll in the Medicaid program as medical equipment dealer and bill for these supplies under your medical equipment dealer number on a HCFA 1500 claim form.

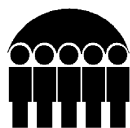
## **G. Occupational Therapy**

The following sections explain general requirements and covered services for occupational therapy.

### **1. General Requirements**

The coverage decision for occupational therapy services is based on the need for the skills of a therapist and not only on the diagnosis. To be covered under home health rehabilitation services, occupational therapy services must:

- ◆ Be provided in the consumer's home.
- ◆ Improve or restore functions that have been impaired by illness or injury or enhance the patient's ability to perform those tasks required for independent functioning.




- ◆ Be reasonable and necessary for the treatment of the patient's illness or injury.
- ◆ Follow an active written treatment plan established by the physician that is reviewed and updated every 30 days. A current plan of treatment must be submitted with the claim for each month. The plan of treatment must include:
  - The patient's functional limitations.
  - Date of onset of conditions being treated.
  - Restorative potential.
  - Modalities of treatment.
  - Goals.
  - Progress notes.
  - Documentation of progress toward the goals.
- ◆ Be performed by a qualified occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified, licensed occupational therapist, as allowed by Iowa licensure.
- ◆ Meet the guidelines defined for restorative, maintenance or trial therapy. See Section III, Item K, **Limits on Rehabilitation Services**.

## 2. Covered Services

Restorative therapy is a covered occupational therapy service when an expectation exists that the therapy will result in a significant practical improvement in the patient's condition.

Where there is a valid expectation of improvement at the time the occupational therapy program is instituted, but the expectation (goal) is not realized, services are covered only up to the time one can reasonably conclude the patient will not improve.

The teaching of activities of daily living and energy conservation to improve the level of independence of a patient is covered when it requires the skill of a licensed therapist and meets the definition of restorative therapy. Refer to Limits on Rehabilitation Services: Restorative Therapy for further information.

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Maintenance therapy, or any activity or exercise program required to maintain a function at the present level, is not a covered service. However, design of a maintenance program and infrequent but periodic evaluation of its effectiveness by the therapist is covered.

Planning and implementing therapeutic tasks are covered. Examples include:

- ◆ Activities to restore sensory-integrative functions.
- ◆ Selection and teaching of tasks designed to restore physical function.
- ◆ Providing motor and tactile activities to increase input and improve responses for a stroke patient.

For coverage of design and monitoring of an occupational therapy maintenance program, see **Limits on Rehabilitation Services: Maintenance Therapy**.

The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and required occupational therapy. A maximum of 13 visits is reimbursable.

For coverage of a trial occupational therapy, see **Limits on Rehabilitation Services: Diagnostic or Trial Therapy**.

Vocational and prevocational assessment and training are not payable by Medicaid. These include services that are related solely to specific employment opportunities, work skills, or work settings.

Occupational therapy frequently necessitates the use of various supplies, e.g., ceramic tiles, leather, etc. The cost of such supplies may be included in the occupational therapy cost center.

## **H. Physical Therapy**

The coverage decision for physical therapy services is based on the need for the skills of a therapist and not only on the diagnosis. The following sections explain general requirements and covered services for physical therapy.



## 1. General Requirements

To be covered under home health rehabilitation services, physical therapy services must:

- ◆ Be provided in the consumer's home.
- ◆ Relate directly and specifically to an active written treatment plan established by the physician after any needed consultation with the qualified physical therapist. The plan must be reviewed and updated every 30 days. A current plan of treatment must be submitted with the claim for each month. The plan must include:
  - The patient's functional limitations.
  - Date of onset of conditions being treated.
  - Restorative potential.
  - Modalities of treatment.
  - Goals.
  - Progress notes.
  - Documentation of progress toward the goals.
- ◆ Be reasonable and necessary to the treatment of the patient's illness, injury, or disabling conditions.
- ◆ Be specific and effective treatment for the patient's medical or disabling conditions.
- ◆ Be of such a level of complexity and sophistication, or the condition of the patient must be such, that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

The initial physical therapy evaluation must be provided by a licensed physical therapist. This evaluation may have been performed by other than the home health agency staff.

A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of a therapist as allowed by Iowa licensure.



The provider must demonstrate that there is a need to establish a safe and effective maintenance program related to a specific illness, injury, or disabling condition. The selection and teaching of tasks to restore physical functions are covered.

- ◆ Meet the guidelines defined for restorative, maintenance or trial therapy. (See Section III, Item K. **Limits on Rehabilitation Services.**)

There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time, based on the patient's restorative potential assessed by the physician. The amount, frequency and duration of the services must be reasonable.

## 2. Covered Services

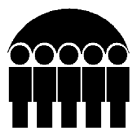
When a patient is under a restorative physical therapy program, the physical therapist regularly reevaluates the patient's condition and adjusts the program. It is expected then, that the physical therapist has designed a maintenance program before discharge.

Consequently, maintenance programs that are not established until after the restorative program has been completed are not considered reasonable and necessary to the treatment of the patient's condition and are excluded from coverage. Refer to **Limits on Rehabilitation Services: Restorative Therapy** for further information.

For coverage of design and monitoring of a physical therapy maintenance program, see **Limits on Rehabilitation Services: Maintenance Therapy.**

For coverage of a physical therapy trial therapy, refer to **Limits on Rehabilitation Services: Diagnostic or Trial Therapy.**

Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require skills of a qualified physical therapist. These are covered when the condition is complicated by other conditions, such as circulatory deficiency or open wounds, or if the service is an integral part of a skilled physical therapy procedure.



Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular, or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, or nursing personnel. Therefore, it is not a covered physical therapy service.

Ultrasound, short wave, and microwave diathermy treatments are considered covered services.

Use of isokinetic or isotonic equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament, or tendon injury or postsurgical trauma. Billing can be made only for the time the therapist actually spends instructing the patient and assessing the patient's progress.


Therapeutic exercises may constitute a physical therapy service due either to the type of exercise employed or the condition of the patient.

Range-of-motion tests must be performed by a qualified physical therapist. Range-of-motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition that has resulted in a loss or restriction of mobility. Documentation must reflect:

- ◆ The degree of motion lost.
- ◆ The normal range of motion.
- ◆ The degree to be restored.

Range-of-motion to unaffected joints only does not constitute a covered physical therapy service.

Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy (work-hardening programs, for example). However, initial instruction for such programs is a covered service.

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## I. Speech Therapy

For speech therapy services, the treatment plan shall additionally reflect the goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

### 1. General Requirements

To be covered by Medicaid as home health rehabilitative services, speech therapy services must:

- ◆ Be provided in the consumer's home;
- ◆ Be related directly to an active written treatment plan that is reviewed and updated every 30 days. A current plan of treatment must be submitted with the claim for each month, include the functional limitations and document progress toward the goals;
- ◆ Follow a treatment plan established by a licensed skilled therapist after consultation with a physician;
- ◆ Be reasonable and necessary to the treatment of the patient's illness or injury;
- ◆ Relate to a specific medical diagnosis or disabling condition which will significantly improve a patient's practical functional level in a reasonable and predictable period of time;
- ◆ Require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable; and
- ◆ Meet the guidelines defined for restorative, maintenance, diagnostic or trial therapy. (See **Limits on Rehabilitation Services.**)

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## 2. Covered Services

Speech therapy activities that are considered covered services include restorative therapy services to:

- ◆ Restore functions affected by illness, injury, or disabling condition resulting in a communication impairment, or
- ◆ Develop functions where deficiencies currently exist.

“Communication impairments” fall into the general categories of disorders of:


- ◆ Voice
- ◆ Fluency
- ◆ Articulation
- ◆ Language
- ◆ Swallowing disorders resulting from any condition other than mental impairment

Treatment of these conditions is payable if restorative criteria are met. Refer to **Limits on Rehabilitation Services: Restorative Therapy.**

Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient’s illness, or disabling condition. Group speech therapy is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

Teaching a patient to use sign language or to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions for these services to be reimbursable. (See **Limits on Rehabilitation Services: Diagnostic or Trial Therapy.**)

Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

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However, designing a maintenance program, in accordance with the requirements of maintenance therapy, and monitoring the progress are covered. For coverage of design and monitoring of a maintenance program, see **Limits on Rehabilitation Services: Maintenance Therapy**.

## J. Supervisory Visits

Payment will be made for supervisory visits two times a month when a registered nurse, acting in a supervisory capacity, provides supervisory visits of services provided by a home health aide under a Medicare-certified home health agency plan of treatment.

### Exceptions:


- ◆ When these visits are provided simultaneously with another Medicaid funded service, they are allowable for administrative costs only.

**Note:** No supervisory visit would be made when the home health agency service is performed by a registered nurse. The submitted care plan must indicate the services that the registered nurse will be providing in addition to supervising the aide or in-home provider.

- ◆ Supervisory visits are required only once every 60 days when the only service provided by the home health agency is home health aide services (no physician-directed nursing assessment has been ordered).

If the nurse provides assessment services pursuant to a physician's order, the home health aide services is not the only service provided. As a result, twice a month supervisory visits are required.

- ◆ When services are provided under the Department's in-home health-related care program (as set forth in 441 Iowa Administrative Code 177), supervisory visits shall be conducted every 60 days (or more often based on medical need).

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## **K. Limits on Rehabilitation Services**

Rehabilitation services include the following components:

- ◆ Physical therapy
- ◆ Occupational therapy
- ◆ Speech therapy

Each of these components must meet one of the following criteria:

- ◆ Restorative therapy,
- ◆ Maintenance therapy, or
- ◆ Diagnostic or trial therapy

### **1. Restorative Therapy**

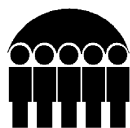
Restorative therapy must be reasonable and necessary to the treatment of the patient's illness, injury, or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment.

There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. "Functional improvement" means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

If at any point of an illness or disabling condition, it is determined that this expectation will not be realized, the services are no longer considered reasonable and necessary.

Examples of covered service include:

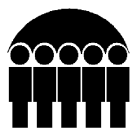
- ◆ Construction of a device which enables a patient to hold a utensil and eat or drink independently.
- ◆ Construction of a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position.
- ◆ Retraining communications skills of a laryngectomized person.



- ◆ Stimulating and retraining a stroke patient who has lost speech or language skills to communicate orally or through augmentative means.
- ◆ Stimulating and training a language or speech delayed child's communication skills to more closely approximate age level.
- ◆ Teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand.
- ◆ Teaching a stroke patient new techniques to enable the patient to perform feeding, dressing, and other activities of daily living as independently as possible.
- ◆ Training an abnormally dysfluent child or adult to speak more fluently.
- ◆ Training new patterns of voice production for a child or adult exhibiting vocally abusive behaviors.
- ◆ Training oral or augmentative communication skills of a mentally or physically handicapped person where a significant discrepancy occurs between the person's cognitive abilities and current level of communication function.

The following examples illustrate situations where restorative therapy is determined reasonable and necessary.

- ◆ A physician has ordered gait evaluation and training for a patient whose gait has been materially impaired by scar tissue resulting from burns. Physical therapy services to evaluate the patient's gait, to establish a gait-training program, and to provide the skilled services necessary to implement the program are covered.
- ◆ A patient who has had a total hip replacement is ambulatory, but demonstrates weakness and is unable to climb stairs safely. Physical therapy is reasonable and necessary to teach the patient to safely climb and descend stairs.
- ◆ A physician orders occupational therapy for a patient who is recovering from a fractured hip and who needs to be taught compensatory and safety techniques with regard to lower extremity dressing, hygiene, toileting, and bathing.



The occupational therapist establishes goals for the patient's rehabilitation (to be approved by the physician), and will undertake the teaching of the techniques necessary for the patient to reach the goals. Occupational therapy services are covered at a duration and intensity appropriate to the severity of the patient's impairment and the response to treatment.

- ◆ A patient with a diagnosis of multiple sclerosis has recently been discharged from the hospital following an exacerbation of her condition. She is now wheelchair-bound and, for the first time, without any expectation of achieving ambulation again.

The physician has ordered physical therapy to select the proper wheelchair for her long-term use and to teach safe use of the wheelchair and safe transfer techniques to the patient and the family.

Physical therapy is reasonable and necessary to evaluate the patient's overall needs, to make the selection of the proper wheelchair, and to teach the patient and family safe use of the wheelchair and proper transfer techniques.

## **2. Maintenance Therapy**

Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes patients with long-term illnesses or disabling condition whose status is stable rather than post-hospital.

Maintenance therapy is also appropriate for patients whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels. Generally, the repetitive exercises to maintain function do not require the services of a qualified physical therapist.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, or other caregiver to carry out the program are considered a covered service. Payment will be made for a maximum of three visits to establish a maintenance program and instruct the caregivers.



Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of twelve months. The plan of treatment must specify the anticipated monitoring of any supervisor. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a re-evaluation is a covered service, if medically necessary. A re-evaluation is considered medically necessary only if:

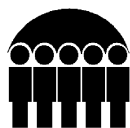
- ◆ There is a significant change in residential or employment situation, or
- ◆ The patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition that previously contraindicated restorative therapy.

A statement by a developmentally disabled patient's interdisciplinary team recommending a re-evaluation and stating the basis for medical necessity is considered as supporting the necessity of a re-evaluation and may expedite approval.

Examples of situations where maintenance therapy could be covered include:

- ◆ A patient with Parkinson's disease who has not been under a restorative physical therapy program may require a maintenance program established by a qualified physical therapist.
- ◆ A patient who has received gait training has reached maximum restoration potential. The physical therapist is teaching the patient and family how to safely perform the activities that are a part of the maintenance program being established.

Although the activities by themselves do not require the skills of a therapist, the visits by the physical therapist to demonstrate and teach the activities are covered, since they are needed to establish the program.



- ◆ A stroke patient (or mentally retarded adult) exhibits deficits in communication function relative to the patient's cognitive abilities, but requires a therapy plan that slowly progresses in complexity and involves repetitious exercises or activities.

A program may be established to help the patient advance through the levels. However, since it is of a less complex design, it does not require the constant contact with a skilled therapist and is payable as a maintenance program only.

- ◆ A mentally retarded adult has reached a plateau in progress in a restorative speech-language therapy program. Potential for further progress seems minimal, though a discrepancy exists between the patient's cognitive skills and communication abilities. A maintenance program may be established to ensure that present level of functioning continues.

### 3. Diagnostic or Trial Therapy

Payment is made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic therapy or trial therapy.

Diagnostic or trial therapy may be appropriate when:

- ◆ The patient does not meet restorative or maintenance therapy criteria.
- ◆ The patient's initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed.
- ◆ The patient needs evaluation in multiple environments to determine their rehabilitative potential adequately.
- ◆ There is a need to assess the patient's response to treatment in the patient's environment.



Trial therapy will not be granted more than once per year for the same issue. If the patient has a previous history of rehabilitative services, trial therapy for the same type of services generally is payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue require documentation reflecting a significant change.

Further diagnostic or trial therapy for the same issue is not considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required. They will be reviewed to determine the medical necessity of the number of hours of service provided.

When a patient has been sufficiently evaluated during diagnostic or trial therapy to determine potential for restorative or maintenance therapy (or lack of therapy potential), diagnostic or trial therapy ends.

At the end of diagnostic or trial therapy, recommend either continuance of services under restorative therapy, continuance of services under maintenance therapy, or discontinuance of services.


When restorative or maintenance therapy is found appropriate, as a result of diagnostic or trial therapy, submit claims noting restorative or maintenance therapy (instead of diagnostic or trial therapy). Continuance of services under restorative or maintenance therapy is reviewed based on the criteria in place for restorative or maintenance therapy.

Diagnostic or trial therapy must additionally meet the following criteria:

- ◆ There must be face-to-face interaction with a licensed therapist. (An aide's services are not payable.)
- ◆ Services must be provided on an individual basis. (Group diagnostic or trial therapy is not payable.)



- ◆ Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the patient's response.
- ◆ For patients who received previous rehabilitation treatment, consideration of trial therapy generally should occur only if the patient has incorporated any regimen recommended during prior treatment into daily life to the extent of the patient's abilities. (For speech therapy, this criterion does not apply if the only goal of prior rehabilitative treatment was to learn the prerequisite speech components.)
- ◆ If the patient has a previous history of rehabilitative services, trial therapy for the same type of services generally is payable only when a significant change has occurred since the last therapy. A "significant change" is considered as having occurred when any of the following exist:
  - New onset.
  - New problem.
  - New need.
  - New growth issue.
  - Surgical intervention that may have caused new rehabilitative potentials.
  - A change in vocational or residential setting that requires a re-valuation of potential.
- ◆ Documentation should include any previous attempt to resolve problems using non-therapy personnel (e.g., residential group home staff, or family members) and whether follow-up programs from previous therapy have been carried out.
- ◆ For referrals from residential, vocational, or other rehabilitation personnel that do not meet present evaluation, restorative, or maintenance criteria, submit with the claim documentation of:
  - The proposed service.
  - The medical necessity.
  - The current medical condition, including any secondary rehabilitative diagnosis.
- ◆ Claims for diagnostic or trial therapy must reflect the progress being made toward the initial diagnostic or trial therapy plan.

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## **L. Nonpayable Intermittent Services**

The following services are not a payable benefit:

- ◆ Homemaker services.
- ◆ Services provided in the home health agency office.
- ◆ Transportation and escort services.
- ◆ Well-child medical care and supervision.

Medicaid patients under the MediPASS program must have the physician's approval for the service to be payable.

Home health agency services for a patient in a Medicaid HMO are covered by the HMO.

Psychiatric nursing services are covered by the Iowa Plan for a person under age 65 with a primary diagnosis of ICD-9 code 290 through 301.99 or 306 through 309.99 or 311 through 314.99.

Medical equipment rental is not reimbursable to a home health agency. Obtain and bill for dressings, durable medical equipment, and other supplies through a medical equipment dealer or pharmacy. (Special consideration may be given to unusual circumstances, such as when a pharmacy or medical equipment dealer is not available in the recipient's community.)

## **M. Basis of Payment for Intermittent Services**

Payment shall be made on an encounter basis. An "encounter" is defined as separately identifiable hours in which home health agency staff provide continuous service to a patient.

Payment of home health agency intermittent services is based on the service provided rather than the classification of the home health agency employee providing the service. Other insurance is primary and must be billed first. A current plan of care must be submitted with each claim.

Patients under the MediPASS program must have the physician's approval for the service to be payable.



## 1. Supplies and Equipment

Payment for supplies will be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy.

Payment of supplies may be made to home health agencies when a medical equipment dealer or pharmacy is not available in the patient's community. A home health agency must enroll as a medical equipment provider in order to be paid for equipment supplies over \$15.

## 2. Service Provided Under an Exception to Policy

When billing services provided under an exception to policy, follow the instructions in the decision letter. A current plan of care and a copy of the exception to policy decision letter must accompany each claim. The claim must include:

- ◆ The correct primary diagnosis.
- ◆ The revenue or procedure code.
- ◆ The number of hours of each service provided.
- ◆ The reimbursement rate identified in the decision letter for each service provided.

## N. Intermittent Procedure Codes and Nomenclature

Home health agency intermittent services are billed using revenue codes. Enter the three-digit code that identifies a specific accommodation or ancillary services.

550	Skilled nursing care
420	Physical therapy
440	Speech therapy
430	Occupational therapy
570	Home health aide
270	Medical supplies
560	Medical social worker



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Show revenue code 001 as the last line on the claim form, indicating total charges for the entire bill.

A unit of service is one visit. Prepare one claim that includes all home health services provided during a calendar month.

Claims submitted without a revenue code and an ICD-9-CM diagnosis code will be denied.

#### **IV. PRIVATE-DUTY NURSING AND PERSONAL CARE SERVICES**

Private-duty nursing and personal care services for children with special needs are covered for Medicaid recipients aged 20 and under when:

- ◆ The services are medically necessary.
- ◆ The services exceed the intermittent criteria.
- ◆ The service planning process has taken place.
- ◆ Prior authorization is approved.

These services are intended to:

- ◆ Promote alternatives to prolonged hospitalizations or institutionalization by providing for medically necessary and effective home care.
- ◆ Provide ongoing nursing support to a technology-dependent child or a child with multiple medical needs related to an acute or chronic medical condition in the home environment.

The objectives of the services are:

- ◆ To provide direct patient care, supervision of family caregivers, and teaching of the necessary skills to care for a medically compromised child at home,
- ◆ To promote quality care and a safe home environment for the patient,
- ◆ To provide for comprehensive and coordinated care in a cost-effective manner, and
- ◆ To reduce the number of hours funded and provided by the program to the minimum level necessary to meet the medical needs of the child safely while ensuring that quality care is maintained in the child's home environment.



Payment for private-duty nursing or personal care services for patients aged 20 and under will be approved if determined to be medically necessary. “Medical necessity” means:

- ◆ The service is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and
- ◆ No other equally effective course of treatment is available or suitable for the patient requesting a service.

The role of the parents is central to the management of home care and must permeate all planning. Use family-centered concepts when working with the family to develop a treatment plan. Also involve the child in the planning of treatment services, based on the child’s age and understanding of the condition.

The services are considered supportive to the care provided to the child by family, foster parents, or delegated caregivers. Whenever possible, teach the nursing regimen to the child, the family, the foster parents, or delegate it to an unlicensed caregiver to achieve the goals and objectives.

Maintenance of the nursing regimen plan of care is the responsibility of the child, family, foster parents, or delegated caregivers, with a registered nurse providing any necessary supervision and follow-up. Decrease care as the family, foster parents, or caregivers become able to meet the client’s needs.

Home health services are directed to support the extra burdens on the parents due to the child’s medical needs. They are not available to meet a family’s normal needs for child care and supervision, such as while a parent works.

## **A. Personal Care Services**

“Personal care services” are services provided by a home health aide which are delegated and supervised by a registered nurse under the direction of the child’s physician. Services may be provided to a child in the child’s place of residence or outside the child’s residence when normal life activities take the recipient outside the place of residence. Some of the care must be provided in the child’s home.



Personal care services do not include:


- ◆ Respite care (a temporary intermission or period of rest for the caregiver to relieve the caregiver of the duties of providing continuous support and care to the child).
- ◆ Services provided to other members of the child's household.
- ◆ Services requiring prior authorization that are provided without regard to the prior authorization process.
- ◆ Assessment and monitoring.
- ◆ Cueing for behavior management.
- ◆ Other services listed in section IV. F, Nonpayable Services

## **B. Private-Duty Nursing**

"Private-duty nursing services" are services provided to a child by a registered nurse or a licensed practical nurse under the direction of the child's physician. Services may be provided in the child's place of residence or outside the child's residence, when normal life activities take the child outside the place of residence. Some of the care must be provided in the child's home.

Private-duty nursing services do not include:

- ◆ Respite care (a temporary intermission or period of rest for the caregiver to relieve the caregiver of the duties of providing continuous support and care to the child).
- ◆ Nurse supervision services, such as chart review, case discussion, or scheduling by a registered nurse.
- ◆ Services provided to other members of the child's household.
- ◆ Services requiring prior authorization that are provided without regard to the prior authorization process.
- ◆ Other services listed in section IV. F, Nonpayable Services.

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## C. Service Planning for Special Needs Children

The child's assigned case manager or service worker is responsible for completing the service planning process. If there is not an assigned service worker or case manager, a Child Health Specialty Clinic nurse will be assigned to this role.

This planning process must be completed for each child before requesting a prior authorization for private-duty nursing or personal care services. (A time-limited authorization may be approved for children who need services before the planning process can be completed. See **Special Circumstances**.)

The planning process must be repeated for each prior authorization request. Eight weeks before the expiration date of an existing prior authorization, ACS staff will notify the provider and the service worker, case manager or Child Health Specialty Clinic staff, by phone. Planning needs to occur within the next three weeks, unless this has been initiated or completed.

If the child will turn 21 within the next 12 months, ACS staff will send an e-mail to the adult and family specialist for the region in which the child resides. The e-mail will advise the region of the need to begin planning for services when the child is no longer eligible for prior-authorized services.

This planning will result in a new prior authorization request and supporting documentation being prepared and submitted at least four weeks before the expiration of the current prior authorization. The planning process is needed to ensure that funding for services is not jeopardized by the failure to complete and timely submit a prior authorization.

### 1. Planning Process

The service worker, case manager or Child Health Specialty Clinic staff will involve in the planning:

- ◆ The family.
- ◆ Providers.
- ◆ Area education agency staff (for children in school).



Others who may be involved when applicable include:

- ◆ Child Health Specialty Clinic staff.
- ◆ Insurance case managers.
- ◆ HMO representatives.
- ◆ Iowa Plan contractor staff.
- ◆ Special program resources.
- ◆ County central point of coordination for children aged 16 through 20.
- ◆ Department of Human Services income maintenance staff.
- ◆ Physicians.
- ◆ Family support people and advocates.
- ◆ Department of Human Services service help desk staff.
- ◆ ISU home- and community-based services specialists.
- ◆ Medicaid policy staff.

At a minimum, the planning should address:

- ◆ What was covered by any prior authorization that will be expiring.
- ◆ Any changes which have occurred.
- ◆ If there were services which could not be covered when the current prior authorization was approved.
- ◆ Definitions of terms, including intermittent, private-duty nursing, personal care, medical necessity, scope of practice, waiver services, in-home health-related care.
- ◆ Hierarchy for the use of insurance, intermittent services, prior authorized services, waiver services, medical transportation, state funded services, and other funding such as county, school and civic organization funding.
- ◆ How different plans for the child interact, such as time frames, uses of services, level of detail, and how families, providers, and others involved in the planning are notified of service approvals.
- ◆ How waiver-funded nursing and home health services can be used.



- ◆ Use of waiver services such as supported community living, homemaker, consumer-directed attendant care, respite, and the requirements for use of gatekeeper services.
- ◆ Enrolled and available waiver providers in the area.
- ◆ Documentation requirements for home health agencies.
- ◆ When and how multiple provider agencies are used.
- ◆ Planning for nonschool days.
- ◆ Exception to policy processes, including who initiates the exception request, who needs to be involved, what needs to be submitted, and the steps to the process.
- ◆ Process for conference calls to be used if problems occur in finalizing the plan.

If services will meet the intermittent guidelines, a prior authorization will not be needed. The service worker, case manager or Child Health Specialty Clinic staff will notify ACS of the resolution.

If it becomes evident during the planning that not all the issues can be resolved, or one or more of the core members of the team does not agree with the plan, a conference call must be scheduled. (See **Conference Call**.)

## 2. Service Authorization

When the planning results in the need for a new prior authorization request to be submitted, the service worker, case manager or Child Health Specialty Clinic staff will request the home health agency to provide a copy of the prior authorization request. (See **Prior Authorization Request** for instructions on preparing form 470-0829, *Prior Authorization Request*.) This will be sent to ACS.

ACS will notify the service worker, case manager or Child Health Specialty Clinic staff if it has not received the new *Prior Authorization Request* four weeks before the expiration of the current authorization.



The service worker, case manager or Child Health Specialty Clinic staff will advise the family that:

- ◆ The home health agency has not submitted the new prior authorization request, and
- ◆ Funding for services may be jeopardized or consideration may need to be given to securing a different provider.

If the prior authorization can be approved as submitted, ACS will notify the service worker, case manager, or Child Health Specialty Clinic staff, who will confirm that the family's need for service has not changed. If the needs remain the same, ACS will approve the prior authorization as requested and return it to the provider.

Other activities needed to implement the decision may include revision of plans, submission of waiver forms, and completion of notices of decision by case managers and service workers.

If the prior authorization cannot be approved as submitted, ACS will notify the service worker, case manager, or Child Health Specialty Clinic staff, who will determine if other services discussed during the planning can be used to meet the need or if a conference call is needed.

### 3. Conference Call

If the issues cannot be resolved through the planning process, the service worker, case manager or Child Health Specialty Clinic staff will:

- ◆ Schedule a conference call by contacting the scheduler at ACS.
- ◆ Provide the names and telephone numbers of those who will participate.

At a minimum, those participating in the call will include:

- ◆ The service worker, case manager or Child Health Specialty Clinic staff.
- ◆ The family.
- ◆ Providers.
- ◆ ACS medical review staff.
- ◆ Area education agency staff (for children in school).



Others participating when applicable include:


- ◆ Child Health Specialty Clinic staff.
- ◆ Insurance case managers.
- ◆ HMO representatives.
- ◆ Iowa Plan contractor staff.
- ◆ Special Program Resources.
- ◆ County central point of coordination for children aged 16 through 20.
- ◆ IM staff.
- ◆ Physicians.
- ◆ Family support people and advocates.
- ◆ Department of Human Services service help desk staff.
- ◆ ISU home- and community-based services specialists.
- ◆ Medicaid policy staff.

Calls will be scheduled at a mutually agreed upon time before the expiration date of the current prior authorization. They should be scheduled as soon as possible to allow adequate time for decisions to be made before the expiration of the prior authorization.

ACS will convene conference calls as scheduled. The service worker, case manager, or Child Health Specialty Clinic staff will either facilitate the call or ensure that a facilitator is designated. At the end of the conference call, the facilitator will provide a verbal summary of the outcome of the discussion.

ACS will complete a written summary of the conference call using the format developed by the Special Needs Children Planning work group. The original will be kept in the consumer's file at ACS and a copy will be sent to the service worker, case manager or Child Health Specialty Clinic staff. The information on the summary will include, at a minimum:

- ◆ The child's name and state ID number.
- ◆ The date the planning conference call was held.
- ◆ The participants in the planning conference call.
- ◆ A brief description of the outcome, including amount and type of services to be provided.

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#### 4. **Special Circumstances**

The service worker, case manager or Child Health Specialty Clinic staff will ensure that a planning discussion occurs in the following situations:

- ◆ A child is discharged from the hospital.
- ◆ A child is determined to be terminally ill.
- ◆ A child's service needs change.
- ◆ Changes in eligibility occur.
- ◆ Responsibility for services transfers from one agency to another.
- ◆ An initial prior authorization request with a proposed plan of care is submitted and no supporting documentation is available.
- ◆ A prior authorization request is submitted for a child aged 16 or older.
- ◆ A current prior authorization needs to be modified.

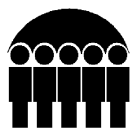
A prior authorization request based on a proposed plan may be approved for a limited period of time, usually not more than four to eight weeks, to allow the regular planning process for services to occur.

When ACS receives a request to modify a current prior authorization, the service worker, case manager or Child Health Specialty Clinic staff will be notified. A mutual decision will be made to initiate planning, using some or all of the planning process, or approve a time-limited modification. Policy staff will be included in this discussion as needed.

#### 5. **Hospital Discharge Planning**

For a child being discharged from a hospital, an initial prior authorization or modification of an existing prior authorization may be approved for a limited period of time. See **Special Circumstances**.

Encourage family support systems to be in place by working with the hospital discharge planner and community mental health support system.



“Support systems” are services, resources, information, training, and emotional support that enable a family to assume responsibility and provide care for a technology-dependent child or a child with a chronic disability in addition to meeting the goals and accomplishing tasks of family life.

The discharging hospital has a responsibility to assist the family to identify potential providers of the home health agency services and to teach the necessary skills to the caregivers within the hospital setting. This teaching can be continued the first several weeks to reinforce skills with the caregivers.

Facility discharge planning includes extensive teaching of the main family caregivers within the facility setting, before discharge of the patient. Teaching must include:

- ◆ An understanding of the child’s diagnosis and prognosis.
- ◆ Ability to provide direct patient care.
- ◆ Demonstrated knowledge of the use and care of needed equipment.
- ◆ Emergency measures in the care of the patient, including emergency preparedness for utility failure.

The family should be centrally involved in the selection process of the home care agency. Ideally, the family should select the home health agency at least two weeks before discharge and notify the agency of the patient referral.

The home health agency should be involved in the development of the home care plan before discharge. Coordination between the discharging hospital and the home health agency should be reflected on the plan of treatment. The care plan must address short-term goals as well as the long term nature of the care required.

Training family members in the care of the child should begin as early as possible in the hospital, but at least within the two weeks before discharge. The training of the family must include:

- ◆ Detailed documentation (written instruction) of the child’s care needs.
- ◆ A systematic process for teaching parents and siblings (when appropriate) the care of the child.



Rooming in while the child is still an inpatient is recommended. Parents should be taught alternative ways of doing things, so they will become comfortable with problem solving regarding the care needs. Proper education of the caregivers regarding actions to take in the case of emergency situations is essential before discharge home.

The discharging hospital should assist the family in locating a community-based pediatrician or other physician who is willing to accept primary care coordination for the patient. The lines of communication must be open between the physician, the family caregivers, and the home health agency.


The parents are central to the management of home care. During all stages of adjusting to home care, it is very important to remember that the parents (or primary caregivers) remain the only “constant” factor in the home care experience over time. They have the accumulated knowledge and experience of their needs, as well as the needs of their child, which a health care provider may not have.

Coordination between the discharge planner or hospital social worker and the home health agency or the person responsible for ensuring psychosocial support must be initiated on an outpatient basis immediately at the time of discharge. Stressors imposed on the family due to the various factors involved in service delivery systems must be recognized.

The goal of all service providers should be to ensure alternative ways of decreasing stress and increasing the effectiveness of the services provided in the most cost-effective manner while enhancing family functioning.

Home care is a lot of work. Families will do better knowing the benefits and limitations up front, rather than getting discouraged because care for their child at home is not what they expected.

Giving the parents honest and factual information helps to better prepare them to the realities of home care. Parents need to know and understand that they have a responsibility in maintaining a business relationship with service providers.

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Often, the depersonalization of home care is difficult for families to cope with but, nonetheless, reality. Presenting this reality before its occurrence helps to prepare the families for the idea that they need to rely on themselves to ensure that the service contracted for is, in fact, provided.

## **D. Prior Authorization Request**

Private-duty nursing or personal care services require prior authorization. Medical personnel will individually review each prior authorization request. Prior authorization requests may be approved, modified, or denied.

The skill level approved for private-duty nursing or personal care services is based on the medical necessity of the child and the Iowa Board of Nursing scope of practice guidelines, not the staffing preference of the provider or family.

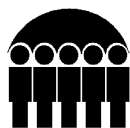
Private-duty nursing or personal care services must be ordered in writing by a physician, as evidenced by the physician's signature on the plan of care.

A prior authorization request can be reviewed without the physician's completed order, but any changes in the order must be communicated to the medical review agency. (The plan of care must be signed within the certification period and attached to the claim for payment.)

The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. Request prior authorization based on the planning process outlined under Service Planning for Special Needs Children. Submit initial requests and requests for renewal on form 470-0829, *Request for Prior Authorization*. (See **Chapter F** for further instructions and a facsimile of this form.)

Mail requests to ACS, Prior Authorization Home Health Agency, Box 9157, Des Moines, IA 50306-3422, or fax them to 515-327-5127. (You must send the original, signed *Request for Prior Authorization* to ACS to support a faxed prior authorization request.)

A request to modify a prior authorization may be made by telephone to **1-888-424-2070** or **515-327-5126**.



The request for prior authorization shall include:

- ◆ A nursing assessment.
- ◆ The plan of care.
- ◆ Supporting documentation showing the planning process.

The request for prior authorization shall include all items identified in Section II as required treatment plan information and shall further include:

- ◆ Any planned surgical interventions and projected timeframes of the surgery.
- ◆ Information regarding the caregiver's desire to:
  - Become involved in the child's care.
  - Adhere to program objectives.
  - Work toward treatment plan goals.
  - Work toward maximum independence.
- ◆ Identification of the types and service delivery levels of all other services to the child, whether or not the services are reimbursable by Medicaid.

For example, all patients should be receiving well-child care from their physician, well child clinic, school-based clinic, and educational services from their area education agency or local education agency or local education agency. Some patients may be involved with Child Health Specialty Clinics, or respite programs. Some may be eligible for private insurance services.

- ◆ If requesting extension of private-duty nursing or personal care, information regarding carry-over or follow-through of the work toward maximum independence by the child and the caregiver. Carry-over and follow-through compatible with the treatment goals must be documented.
- ◆ The expected number of private-duty nursing registered nurse hours, private-duty nursing licensed practical nurse hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. The total number of hours requested must exactly match the number of hours on the treatment plan.

**Note:** Prior authorization approvals will not be granted for treatment plans that exceed 16 hours of home health agency services per day.

- ◆ If the patient is currently hospitalized, the projected date of discharge.



Prior authorization for home care services will not be approved before:

- ◆ The regular service planning process or the planning process for special circumstances is completed.
- ◆ The designated review agent receives a telephone contact, fax, or a written request from the provider for prior authorization of the services.

Prior authorizations are recipient-specific, not provider-specific. Agencies that accept patients who have a current approved prior authorization from the patient's previous home health agency should notify ACS by letter to receive a copy of the current prior authorization.

To request a transfer of the prior authorization to a new home health agency, notify ACS Prior Authorization Unit in writing. The written request must address the reasons for the agency change, the effective day of the change, and any changes in the services to be provided.

If you have questions related to prior authorization, you may telephone ACS at 1-888-424-2070 or 515-327-5127.


## **E. Place of Service**

Private-duty nursing and personal care services are provided to a patient in the patient's place of residence or outside the patient's residence, when normal life activities take the patient outside the place of residence. Some of the care must be provided in the child's home.

Additional hours of services will not be authorized outside the patient's residence beyond what would normally be authorized in the residence. If a patient wishes to receive nursing services to attend school or other activities outside the home, but does not need nursing services in the home, nursing services cannot be authorized.

The need for care to participate in activities outside the home is not a basis for authorizing additional hours of service.

Services provided in nursing facilities, skilled nursing facilities, intermediate care facilities for the mentally retarded, or hospitals are not payable. Services that are provided in the home health agency office are not payable.

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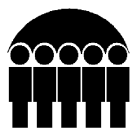
## **F. Nonpayable Services**

The following services are not payable as private-duty nursing or personal care:

- ◆ Homemaker services.
- ◆ Homework assistance.
- ◆ Medical transportation.
- ◆ Nurse supervision services, such as chart review, case discussion, or scheduling by a registered nurse.
- ◆ Respite care (temporary intermission or period of rest for the caregiver that relieves the caregiver of the duties of providing continuous support and care to the patient).
- ◆ Service requested for nonmedical reasons.
- ◆ Services provided to other members of the patient's household.
- ◆ Services requiring prior authorization that are provided without regard to the prior authorization process.
- ◆ Services to patients aged 21 and over.
- ◆ Two Medicaid services provided simultaneously.
- ◆ Well-child medical care and supervision.

Assessment and monitoring which require the skills of a licensed nurse are covered under private-duty nursing, but are not covered under personal care.

Medical equipment rental is not reimbursable to a home health agency. Supplies incidental to a patient's care may be billed monthly (i.e., syringes for Prolixin injections).



Obtain and bill for dressings, durable medical equipment, and other supplies through a medical equipment dealer or pharmacy. (Special consideration may be given to unusual circumstances; e.g., a pharmacy or medical equipment dealer is not available in the recipient's community.)

Patients under the MediPASS program must have the physician's approval for the service to be payable.

Home health agency services for a patient in a Medicaid HMO are covered by the HMO.

The Iowa Department of Public Health may certify home health agencies to participate as child health centers and provide EPSDT screening services. Those agencies will be paid for health screening examinations for Medicaid-eligible patients under 21 years of age. Those agencies should enroll as screening centers to provide EPSDT screening services.


## **G. Basis of Payment**

Payment to a home health agency for private-duty nursing or personal care services is on an hourly fee-for-service basis. Bill for services on a UB-92 claim form. As a general rule, billing is per calendar month. Only the level of care approved on the prior authorization can be billed.

Reimbursement is made for an hourly unit of service based on a fee schedule. Enhanced payment under the interim fee schedule will be made available for services to children who are technology-dependent (ventilator dependent or with a medical condition so unstable as to otherwise require intensive care in a hospital).

A person is considered ventilator dependent when the person:

- ◆ Is unable to initiate spontaneous breathing, and
- ◆ Needs a life sustaining medical device for respiration which meets the following definition: "A volume-cycled, mechanical device, including but not limited to adjustments for respiratory rates and tidal volume and oxygen concentration, that provides life sustaining respiration."


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## H. Procedure Codes and Nomenclature

HCPCS codes have been established for billing. One unit equals one hour. Claims submitted without a procedure code and an ICD-9-CM diagnosis code will be denied.

<u>Code</u>	<u>Description</u>
S9122	Home health aide or certified nurse assistant providing care in the home; per hour
S9123	Nursing care in the home by registered nurse; per hour
S9124	Nursing care in the home by licensed practical nurse; per hour

For nursing services provided at the enhanced rate, submit claims using the same code. The approved prior authorization form will reflect reimbursement at the enhanced rate.

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## I. REQUEST FOR PRIOR AUTHORIZATION FORM AND INSTRUCTIONS

### A. How to Use

For services requiring prior approval (see Chapter E), form 470-0829, *Request for Prior Authorization*, must be completed and submitted to the fiscal agent. The request will be reviewed by the Medical Unit and a determination of coverage will be made. When a determination has been made, the form will be returned to you. Do not use this form unless prior approval is required by Medicaid for the service being provided.

If the service is approved for coverage, you may then submit your claim for reimbursement. **Important:** Do not return the prior authorization form. You need to place the prior authorization number in the appropriate location on your claim form. (Consult the claim form instructions.) Using this number, the computer will then verify that the service has been approved for payment.

### B. Facsimile of Request for Prior Authorization

(See page 3.)

### C. Instructions for Completing Request for Prior Authorization

1. PATIENT NAME  
Complete the last name, first name and middle initial of the patient. Use the *Medical Assistance Eligibility Card* for verification.
2. PATIENT IDENTIFICATION NUMBER  
Copy this number directly from the *Medical Assistance Eligibility Card*. This number must be eight positions in length (seven numeric digits and one alphabetical character).



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3. COUNTY NO.

This is the number of the county where the recipient resides. It may be copied from the *Medical Assistance Eligibility Card*. This is a two-digit code. This area is optional.

4. DATE OF BIRTH

Copy the patient's date of birth directly from the *Medical Assistance Eligibility Card*. Use two digits for each: month, day, year (MM, DD, YY).

5. PROVIDER PHONE NO.

Completing this area may expedite the processing of your *Request for Prior Authorization*. This area is optional.

6. PROVIDER NO.

Leave blank.

7. PAY TO PROVIDER NO.

Enter the seven-digit provider number assigned to you by the Iowa Medicaid Program.

8. DATES COVERED BY THIS REQUEST

Enter the appropriate date span. Be sure to include the date of service.

Complete this item using two digits for each: month, day, year (MM, DD, YY).

If this request is approved, it will be valid only for this period of time.

9. PROVIDER NAME

Enter the name of the provider requesting prior authorization.

10. STREET ADDRESS

Enter the street address of the provider requesting prior authorization.

11. CITY, STATE, ZIP

Enter the city, state and zip of the provider requesting prior authorization.

12. PRIOR AUTHORIZATION NO.

Leave blank. The fiscal agent will assign a number if the service is approved. You will then place this number in the appropriate area on the claim form.

## Iowa Department of Human Services

**REQUEST FOR PRIOR AUTHORIZATION**

(PLEASE TYPE - ACCURACY IS IMPORTANT)

1. Patient Name (Last) (First) (Initial)			2. Patient Identification No.		3. Co. No.		4. Date of Birth Mo. Day Year		
5. Provider Phone No.		6. Provider No.		7. Pay to Provider No.		8. Dates Covered by Request			
						From		To	
9. Provider Name						Mo.	Day	Year	Mo. Day Year
10. Street Address						12. PRIOR AUTHORIZATION NO. (To be assigned by fiscal agent) Enter this number in the appropriate box when submitting the claim form for the services authorized.			
11. City, State, Zip									
13. Reasons For Request (use additional sheet if necessary)									

**SERVICES TO BE AUTHORIZED**

14. Line No.	15. Describe Procedure, Supply, Drug To Be Provided or Diagnosis Description	16. Procedure, Supply, Drug or Diagnosis Code*	17. Units of Service	18. Leave Blank Authorized Units	19. Amount	20. Leave Blank Authorized Amount	21. Leave Blank Status
01							
02							
03							
04							
05							

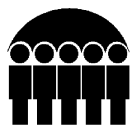
IF THE PROVIDER OF THESE SERVICES WILL BE OTHER THAN THE PROVIDER NAMED IN BOX 9, PLEASE COMPLETE THIS PORTION.

22. Provider Name		23. Telephone No.	24. Provider No.	25. Pay to Provider No.
26. Street Address		City		State Zip
<p>IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the recipient's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the recipient continues to be eligible for Medicaid.</p>			27. Requesting provider	
			<p>_____ Signature of Authorized Representative Date</p>	

**FISCAL AGENT USE ONLY**

28. MEDICAID BENEFITS ARE HEREBY <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED FOR THE RECIPIENT UNDER TITLE XIX, THIS AUTHORIZATION APPLIED ONLY TO THE ELIGIBLE PERSON ABOVE FOR THE SERVICE(S) SPECIFICALLY APPROVED ABOVE.	
29. Comments or Reasons for Denial of Benefits	
<p>*PROCEDURE, SUPPLY, DRUG OR DIAGNOSIS CODES AUTHORIZED ON THIS REQUEST MUST BE THE SAME CODES ENTERED ON THE CLAIM FORM</p>	
30. Signature	
<p>_____ Fiscal Agent's Authorized Representative Date</p>	

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13. REASON FOR REQUEST

Provide the required information in this area for the type of approval being requested. Refer to Chapter E of this manual. (For enteral products, enter the number of cans or packets administered per day.)

SERVICES TO BE AUTHORIZED

14. LINE NO.

No entry is required.

15. DESCRIBE PROCEDURE, SUPPLY, DRUG TO BE PROVIDED OR  
DIAGNOSIS DESCRIPTION

Enter the description of the service or services to be authorized. (For enteral products, enter the product name and NDC number.)

16. PROCEDURE, SUPPLY, DRUG OR DIAGNOSIS CODE

Enter the appropriate code. For prescription drugs, enter the appropriate NDC. For other services or supplies, enter the proper HCPCS code.

17. UNITS OF SERVICE

Complete with the amount or number of times the service is to be performed. (For enteral products, enter the number of cans or packets dispensed for the time span requested.)

18. AUTHORIZED UNITS

Leave blank. The fiscal agent will indicate the number of authorized units.

19. AMOUNT

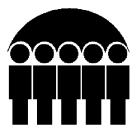
Enter the amount that will be charged for this line item.

20. AUTHORIZED AMOUNT

Leave blank. The fiscal agent will indicate the authorized amount or indicate that payment will be based on the fee schedule or maximum fee depending on the service provided.

21. STATUS

Leave blank. The fiscal agent will indicate "A" for approved or "D" for denied.



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22. PROVIDER NAME

Complete the name of the provider who will provide services, if other than requestor of prior authorization.

23. TELEPHONE NO.

Enter the telephone number of the provider who will provide services, if other than requestor of prior authorization. This area is optional.

24. PROVIDER NO.

Enter the seven-digit Medicaid provider number of the treating provider, if other than requestor of prior authorization.

25. PAY TO PROVIDER NO.

Enter the seven-digit group provider number for the treating provider, if other than requestor of prior authorization.

26. STREET ADDRESS, CITY, STATE, ZIP

Complete the street address, city, state and zip of the provider who will provide services, if other than requestor of prior authorization.

27. REQUESTING PROVIDER

Enter the signature of the provider or authorized representative requesting prior authorization. Also, indicate the date the request was signed.

FISCAL AGENT USE ONLY

28. MEDICAID BENEFITS REQUESTED ARE HEREBY

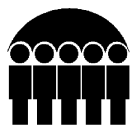
Do not complete. The fiscal agent will complete this item after evaluating the request.

29. COMMENTS OR REASON FOR DENIAL OF BENEFITS

Do not complete. The fiscal agent will complete this section should this request be denied.

30. SIGNATURE

Do not complete. The person making the final decision on this request will sign and date.



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## D. Electronic Prior Authorization Requests

Under the Health Insurance Portability and Accountability Act, there is an electronic transaction for Prior Authorization requests (278 transaction). However, there is no standard to use in submitting additional documentation electronically. Therefore, if you want to submit a prior authorization request electronically, the additional documentation must be submitted on paper using the following procedure:

- ◆ Staple the additional information to form 470-3970, *Prior Authorization Attachment Control*. (See the previous page for an example of this form.)
- ◆ Complete the “attachment control number” with the same number submitted on the electronic prior authorization request. ACS will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the request, please contact the person in your facility responsible for electronic claims billing.
- ◆ Mail the *Prior Authorization Attachment Control* with attachments to:

ACS State Healthcare  
P.O. Box 14422  
Des Moines, IA 50306-3422

Or FAX the information to the Prior Authorization Unit at: 515-327-5127

Once ACS receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

## Iowa Medicaid Program

**Prior Authorization Attachment Control**

Please use this form when submitting a prior authorization electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic prior authorization. Otherwise the electronic prior authorization and paper attachment cannot be matched up.

**Attachment Control Number**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**Provider Name** \_\_\_\_\_

**Pay-to-Provider Number**

--	--	--	--	--	--	--

**Recipient Name** \_\_\_\_\_

**Recipient State ID Number**

--	--	--	--	--	--	--	--

**Date of Service**     /     /

**Type of Document**


---




---



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**RETURN THIS DOCUMENT WITH ATTACHMENTS TO:**

**ACS State Healthcare**  
**P.O. Box 9157**  
**Des Moines, IA 50306-3422**  
**PA FAX: 515-327-5127**

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## II. INSTRUCTIONS AND CLAIM FORM

### A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the UB-92 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (\*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

*For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.*

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	PROVIDER'S NAME, ADDRESS & TELEPHONE NUMBER	<b>OPTIONAL</b> – Enter the complete name, address, and phone number of the billing facility or service supplier.
2.	PAYER CONTROL NUMBER	<b>LEAVE BLANK.</b>
3.	PATIENT CONTROL NUMBER	<b>OPTIONAL</b> – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.



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4.	TYPE OF BILL	<p><b>REQUIRED*</b> – Enter a three-digit number consisting of one digit from each of the following categories in this sequence:</p> <p>First digit      Type of facility  Second digit      Bill classification  Third digit      Frequency</p> <p><u>Type of Facility</u></p> <p>1    Hospital or psychiatric medical institution for children (PMIC)  2    Skilled nursing facility  3    Home health agency  7    Rehabilitation agency  8    Hospice</p> <p><u>Bill Classification</u></p> <p>1    Inpatient hospital, inpatient SNF or hospice (nonhospital based)  2    Hospice (hospital based)  3    Outpatient hospital, outpatient SNF or hospice (hospital based)  4    Hospital referenced laboratory services, home health agency, rehabilitation agency</p> <p><u>Frequency</u></p> <p>1    Admit through discharge claim  2    Interim – first claim  3    Interim – continuing claim  4    Interim – last claim</p>
5.	FEDERAL TAX NUMBER	<b>OPTIONAL</b> – No entry required.
6.	STATEMENT COVERS PERIOD	<b>REQUIRED</b> – Enter the month, day, and year under both the From and To categories for the period.



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7.	COVERED DAYS	<b>REQUIRED FOR INPATIENT*</b> –  <u>Inpatient, PMIC, and SNF</u> – Enter the number of covered days. Do not use the day of discharge in your calculations.  <u>Rehabilitation Agency</u> – Enter the number of days the patient was seen in this billing period. The number of days is used to determine copayment liability.  <u>Hospice Services and Home Health Agencies</u> – Leave blank.
8.	NONCOVERED DAYS	<b>REQUIRED FOR INPATIENT, WHERE APPLICABLE*</b> –  <u>Inpatient, PMIC, and SNF</u> – Enter the number of non-covered days, if applicable. Do not use the day of discharge in your calculations.  <u>Hospice Services, Rehabilitation, and Home Health Agencies</u> – Leave blank.
9.	COINSURANCE DAYS	<b>OPTIONAL</b> – No entry required.
10.	LIFETIME RESERVE DAYS	<b>OPTIONAL</b> – No entry required.
11.	UNLABELED FIELD	<b>OPTIONAL</b> – No entry required.
12.	PATIENT NAME	<b>REQUIRED</b> – Enter the last name, first name, and middle initial of the recipient. Use the <i>Medical Assistance Eligibility Card</i> for verification.
13.	PATIENT ADDRESS	<b>OPTIONAL*</b> – Enter the full address of the recipient.
14.	PATIENT BIRTHDATE	<b>OPTIONAL</b> – Enter the recipient's birthdate as month, day, and year. Completing this field may expedite processing of your claim.
15.	PATIENT SEX	<b>REQUIRED</b> – Enter the patient's sex.



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16.	PATIENT MARITAL STATUS	<b>OPTIONAL</b> – No entry required.																																																												
17.	ADMISSION DATE	<b>REQUIRED*</b> –  <u>Inpatient, PMIC, and SNF</u> – Enter the date of admission for inpatient services.  <u>Outpatient</u> – Enter the dates of service.  <u>Home Health Agency and Hospice</u> – Enter the date of admission for care.  <u>Rehabilitation Agency</u> – No entry required.																																																												
18.	ADMISSION HOUR	<b>REQUIRED FOR INPATIENT/PMIC/SNF</b> – The following chart consists of possible admission times and a corresponding code. Enter the code that corresponds to the hour patient was admitted for inpatient care.  <table> <thead> <tr> <th><u>Code</u></th><th><u>Time - AM</u></th><th><u>Code</u></th><th><u>Time - PM</u></th></tr> </thead> <tbody> <tr> <td>00</td><td>12:00 - 12:59</td><td>12</td><td>12:00 - 12:59</td></tr> <tr> <td></td><td>Midnight</td><td></td><td>Noon</td></tr> <tr> <td>01</td><td>1:00 - 1:59</td><td>13</td><td>1:00 - 1:59</td></tr> <tr> <td>02</td><td>2:00 - 2:59</td><td>14</td><td>2:00 - 2:59</td></tr> <tr> <td>03</td><td>3:00 - 3:59</td><td>15</td><td>3:00 - 3:59</td></tr> <tr> <td>04</td><td>4:00 - 4:59</td><td>16</td><td>4:00 - 4:59</td></tr> <tr> <td>05</td><td>5:00 - 5:59</td><td>17</td><td>5:00 - 5:59</td></tr> <tr> <td>06</td><td>6:00 - 6:59</td><td>18</td><td>6:00 - 6:59</td></tr> <tr> <td>07</td><td>7:00 - 7:59</td><td>19</td><td>7:00 - 7:59</td></tr> <tr> <td>08</td><td>8:00 - 8:59</td><td>20</td><td>8:00 - 8:59</td></tr> <tr> <td>09</td><td>9:00 - 9:59</td><td>21</td><td>9:00 - 9:59</td></tr> <tr> <td>10</td><td>10:00 - 10:59</td><td>22</td><td>10:00 - 10:59</td></tr> <tr> <td>11</td><td>11:00 - 11:59</td><td>23</td><td>11:00 - 11:59</td></tr> <tr> <td></td><td></td><td>99</td><td>Hour unknown</td></tr> </tbody> </table>	<u>Code</u>	<u>Time - AM</u>	<u>Code</u>	<u>Time - PM</u>	00	12:00 - 12:59	12	12:00 - 12:59		Midnight		Noon	01	1:00 - 1:59	13	1:00 - 1:59	02	2:00 - 2:59	14	2:00 - 2:59	03	3:00 - 3:59	15	3:00 - 3:59	04	4:00 - 4:59	16	4:00 - 4:59	05	5:00 - 5:59	17	5:00 - 5:59	06	6:00 - 6:59	18	6:00 - 6:59	07	7:00 - 7:59	19	7:00 - 7:59	08	8:00 - 8:59	20	8:00 - 8:59	09	9:00 - 9:59	21	9:00 - 9:59	10	10:00 - 10:59	22	10:00 - 10:59	11	11:00 - 11:59	23	11:00 - 11:59			99	Hour unknown
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19.	TYPE OF ADMISSION	<b>REQUIRED FOR INPATIENT/PMIC/SNF</b> – Enter the code corresponding to the priority level of this inpatient admission.  1 Emergency 2 Urgent 3 Elective 4 Newborn 9 Information unavailable
20.	SOURCE OF ADMISSION	<b>REQUIRED FOR INPATIENT/PMIC/SNF</b> – Enter the code that corresponds to the source of this admission.  1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from a hospital 5 Transfer from a skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/law enforcement 9 Information unavailable
21.	DISCHARGE HOUR	<b>REQUIRED FOR INPATIENT/PMIC/SNF</b> – The following chart consists of possible discharge times and a corresponding code. Enter the code that corresponds to the hour patient was discharged from inpatient care.  See <b>Field 18, Admission Hour</b> , for instructions for accepted discharge hour codes.



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22.	PATIENT STATUS	<p><b>REQUIRED FOR INPATIENT/PMIC/SNF</b> – Enter the code that corresponds to the status of the patient at the end of service.</p> <p>01 Discharged to home or self care (routine discharge)</p> <p>02 Discharged/transferred to other short-term general hospital for inpatient care</p> <p>03 Discharged/transferred to a skilled nursing facility (SNF)</p> <p>04 Discharged/transferred to an intermediate care facility (ICF)</p> <p>05 Discharged/transferred to another type of institution for inpatient care or outpatient services</p> <p>06 Discharged/transferred to home with care of organized home health services</p> <p>07 Left care against medical advice or otherwise discontinued own care</p> <p>08 Discharged/transferred to home with care of home IV provider</p> <p>10 Discharged/transferred to mental health care</p> <p>11 Discharged/transferred to Medicaid certified rehabilitation unit</p> <p>12 Discharged/transferred to Medicaid certified substance abuse unit</p> <p>13 Discharged/transferred to Medicaid certified psychiatric unit</p> <p>20 Expired</p> <p>30 Remains a patient or is expected to return for outpatient services (valid only for nonDRG claims)</p>
23.	MEDICAL/ HEALTH RECORD NUMBER	<p><b>OPTIONAL</b> – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.</p>



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24. – 30.

CONDITION  
CODES

**CONDITIONAL\*** – Enter corresponding codes to indicate whether or not treatment billed on this claim is related to any condition listed below.

Up to seven codes may be used to describe the conditions surrounding a patient's treatment.

General

- 01 Military service related
- 02 Condition is employment related
- 03 Patient covered by an insurance not reflected here
- 04 HMO enrollee
- 05 Lien has been filed

Inpatient Only

- 80 Neonatal level II or III unit
- 81 Physical rehabilitation unit
- 82 Substance abuse unit
- 83 Psychiatric unit
- X3 IFMC approved lower level of care, ICF
- X4 IFMC approved lower level of care, SNF
- 91 Respite care

Outpatient Only

- 84 Cardiac rehabilitation program
- 85 Eating disorder program
- 86 Mental health program
- 87 Substance abuse program
- 88 Pain management program
- 89 Diabetic education program
- 90 Pulmonary rehabilitation program
- 98 Pregnancy indicator – outpatient or rehabilitation agency



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		<u>Special Program Indicator</u> A1 EPSDT A2 Physically handicapped children's program A3 Special federal funding A4 Family planning A5 Disability A6 Vaccine/Medicare 100% payment A7 Induced abortion – danger to life A8 Induced abortion – victim rape/incest A9 Second opinion surgery  <u>Home Health Agency</u> (Medicare not applicable) XA Condition stable XB Not homebound XC Maintenance care XD No skilled service
31.	UNLABELED FIELD	<b>OPTIONAL</b> – No entry required.
32. – 35. A. & B.	OCCURRENCE CODES AND DATES	<b>REQUIRED IF APPLICABLE*</b> – If any of the occurrences listed below is applicable to this claim, enter the corresponding code and the month, day, and year of that occurrence.  <u>Accident Related</u> 01 Auto accident 02 No fault insurance involved, including auto accident/other 03 Accident/tort liability 04 Accident/employment related 05 Other accident 06 Crime victim



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		<u>Insurance Related</u> 17 Date outpatient occupational plan established or reviewed 24 Date insurance denied 25 Date benefits terminated by primary payer 27 Date home health plan was established or last reviewed A3 Medicare benefits exhausted  <u>Other</u> 11 Date of onset
36. A. & B.	OCCURRENCE SPAN CODES AND DATES	<b>OPTIONAL</b> – No entry required.
37. A. – C.	TRANSACTION CONTROL NUMBER	<b>LEAVE BLANK.</b>
38.	RESPONSIBLE PARTY NAME AND ADDRESS	<b>OPTIONAL</b> – No entry required.
39. – 41. a. – d.	VALID CODES AND AMOUNTS	<b>OPTIONAL</b> – No entry required.
42.	REVENUE CODE	<b>REQUIRED</b> – Enter the appropriate corresponding revenue code for each item or service billed. Replace the “X” with a subcategory code, where appropriate, to clarify the code. Please note that all listed revenue codes are not payable by Medicaid. If you have questions concerning payment for a specific item/service, please call Provider Relations at 1-800-338-7909 or 515-327-5120 (in Des Moines).



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**11X Room & Board – Private  
(medical or general)**  
Routine service charges for single bed rooms.

Subcategories

- 0 General classifications
- 1 Medical/surgical/GYN
- 2 OB
- 3 Pediatric
- 4 Psychiatric
- 6 Detoxification
- 7 Oncology
- 8 Rehabilitation
- 9 Other

**12X Room & Board – Semi-Private Two Bed  
(medical or general)**  
Routine service charges incurred for  
accommodations with two beds.

Subcategories

- 0 General classifications
- 4 Sterile environment
- 7 Self care
- 9 Other

**13X Room & Board – Semi-Private Three and Four  
Beds (medical or general)**  
Routine service charges incurred for  
accommodations with three and four beds.

Subcategories

- 0 General classifications
- 4 Sterile environment
- 7 Self care
- 9 Other



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**14X Private (deluxe)**

Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

Subcategories

- 0 General classifications
- 4 Sterile environment
- 7 Self care
- 9 Other

**15X Room & Board – Ward (medical or general)**

Routine service charge for accommodations with five or more beds.

Subcategories

- 0 General classifications
- 4 Sterile environment
- 7 Self care
- 9 Other

**16X Other Room & Board**

Any routine service charges for accommodations that cannot be included in the more specific revenue center codes. Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.



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Subcategories

- 0 General classifications
- 4 Sterile environment
- 7 Self care
- 9 Other

**17X Nursery**

Charges for nursing care to newborn and premature infants in nurseries.

Subcategories

- 0 General classification
- 1 Newborn
- 2 Premature
- 5 Neonatal ICU
- 9 Other

**18X Leave of Absence**

Charges for holding a room or bed for a patient while the patient is temporarily away from the provider.

Subcategory

- 5 Nursing home (for hospitalization)

**20X Intensive Care**

Routine service for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Subcategories

- 0 General classification
- 1 Surgical
- 2 Medical
- 3 Pediatric
- 4 Psychiatric
- 6 Post ICU
- 7 Burn care
- 8 Trauma
- 9 Other intensive care



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**21X Coronary Care**

Routine service charge for medical care provided to patients with coronary illnesses requiring a more intensive level of care than is rendered in the general medical care unit.

Subcategories

- 0 General classification
- 1 Myocardial infarction
- 2 Pulmonary care
- 3 Heart transplant
- 4 Post CCU
- 9 Other coronary care

**22X Special Charges**

Charges incurred during an inpatient stay or on a daily basis for certain services.

Subcategories

- 0 General classification
- 1 Admission charge
- 2 Technical support charge
- 3 U.R. service charge
- 4 Late discharge, medically necessary
- 9 Other special charges

**23X Incremental Nursing Charge Rate**

Subcategories

- 0 General classification
- 1 Nursery
- 2 OB
- 3 ICU
- 4 CCU
- 9 Other

**24X All Inclusive Ancillary**

A flat rate charge incurred on either a daily or total stay basis for ancillary services only.

Subcategories

- 0 General classification
- 9 Other inclusive ancillary



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**25X Pharmacy**

Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under direction of licensed pharmacies.

Subcategories

- 0 General classification
- 1 Generic drugs
- 2 Nongeneric drugs
- 3 Take home drugs
- 4 Drugs incident to other diagnostic services
- 5 Drugs incident to radiology
- 6 Experimental drugs
- 7 Nonprescription
- 8 IV solutions
- 9 Other pharmacy

**26X IV Therapy**

Equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment. This code should be used only when a discrete service unit exists.

Subcategories

- 0 General classification
- 1 Infusion pump
- 2 IV therapy/pharmacy services
- 3 IV therapy/drug/supply delivery
- 4 IV therapy/supplies
- 9 Other IV therapy

**27X Medical/Surgical Supplies and Devices**  
**(also see 62X, an extension of 27X)**

Charges for supply items required for patient care.



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Subcategories

- 0 General classification
- 1 Nonsterile supply
- 2 Sterile supply
- 3 Take home supplies
- 4 Prosthetic/orthotic devices
- 5 Pacemaker
- 6 Intraocular lens
- 7 Oxygen – take home
- 8 Other implants
- 9 Other supplies/devices

**28X Oncology**

Charges for the treatment of tumors and related diseases.

Subcategories

- 0 General classification
- 9 Other oncology

**29X Durable Medical Equipment  
(other than renal)**

Charges for medical equipment that can withstand repeated use (excluding renal equipment).

Subcategories

- 0 General classification
- 1 Rental
- 2 Purchase of new DME
- 3 Purchase of used DME
- 4 Supplies/drugs for DME effectiveness  
(home health agency only)
- 9 Other equipment

**30X Laboratory**

Charges for the performance of diagnostic and routine clinical laboratory tests. For outpatient services, be sure to indicate the code for each lab charge in UB-92 form field number 44.



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Subcategories

- 0 General classification
- 1 Chemistry
- 2 Immunology
- 3 Renal patient (home)
- 4 Nonroutine dialysis
- 5 Hematology
- 6 Bacteriology and microbiology
- 9 Other laboratory

**31X Laboratory – Pathological**

Charges for diagnostic and routine laboratory tests on tissues and cultures.

For outpatient services, indicate the CPT code for each lab charge in UB-92 form field number 44.

Subcategories

- 0 General classification
- 1 Cytology
- 2 Histology
- 4 Biopsy
- 9 Other

**32X Radiology – Diagnostic**

Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining and interpreting of radio and fluorographs.

Subcategories

- 0 General classification
- 1 Angiocardiology
- 2 Arthrography
- 3 Arteriography
- 4 Chest x-ray
- 9 Other



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**33X Radiology – Therapeutic**

Charges for therapeutic radiology services and chemotherapy required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances.

Subcategories

- 0 General classification
- 1 Chemotherapy – injected
- 2 Chemotherapy – oral
- 3 Radiation therapy
- 5 Chemotherapy – IV
- 9 Other

**34X Nuclear Medicine**

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.

Subcategories

- 0 General classification
- 1 Diagnostic
- 2 Therapeutic
- 9 Other

**35X CT Scan**

Charges for computed tomographic scans of the head and other parts of the body.

Subcategories

- 0 General classification
- 1 Head scan
- 2 Body scan
- 9 Other CT scans



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**36X Operating Room Services**

Charges for services provided to patients by those specifically trained nursing personnel providing assistance to physicians in the performance of surgical and related procedures during and immediately following surgery.

Subcategories

- 0 General classification
- 1 Minor surgery
- 2 Organ transplant – other than kidney
- 7 Kidney transplant
- 9 Other operating room services

**37X Anesthesia**

Charges for anesthesia services in the hospital.

Subcategories

- 0 General classification
- 1 Anesthesia incident to radiology
- 2 Anesthesia incident to other diagnostic services
- 4 Acupuncture
- 9 Other anesthesia

**38X Blood**

Charges for blood must be separately identified for private payer purposes.

Subcategories

- 0 General classification
- 1 Packed red cells
- 2 Whole blood
- 3 Plasma
- 4 Platelets
- 5 Leukocytes
- 6 Other components
- 7 Other derivatives (cryoprecipitates)
- 9 Other blood



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**39X Blood Storage and Processing**

Charges for the storage and processing of whole blood.

Subcategories

- 0 General classification
- 1 Blood administration
- 9 Other blood storage and processing

**40X Other Imaging Services**

Subcategories

- 0 General classification
- 1 Diagnostic mammography
- 2 Ultrasound
- 3 Screening mammography
- 4 Positron emission tomography
- 9 Other imaging services

**41X Respiratory Services**

Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure. Charges for other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Subcategories

- 0 General classification
- 1 Inhalation services
- 3 Hyperbaric oxygen therapy
- 9 Other respiratory services

**42X Physical Therapy**

Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.



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Subcategories

- 0 General classification
- 1 Visit charge
- 2 Hourly charge
- 3 Group rate
- 4 Evaluation or reevaluation
- 9 Other occupational therapy/trial occupational therapy – rehab agency

**43X Occupational Therapy**

Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of patients.

Subcategories

- 0 General classification
- 1 Visit charge
- 2 Hourly charge
- 3 Group rate
- 4 Evaluation or reevaluation
- 9 Other occupational therapy/trial occupational therapy – rehab agency

**44X Speech – Language Pathology**

Charges for services provided to those with impaired functional communication skills.

Subcategories

- 0 General classification
- 1 Visit charge
- 2 Hourly charge
- 3 Group rate
- 4 Evaluation or reevaluation
- 9 Other speech-language pathology/trial speech therapy – rehab agency

**45X Emergency Room**

Charges for emergency treatment to those ill and injured persons requiring immediate unscheduled medical or surgical care.

Subcategories

- 0 General classification
- 9 Other emergency room



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**46X Pulmonary Function**

Charges for tests measuring inhaled and exhaled gases. Charges for the analysis of blood and for tests evaluating the patient's ability to exchange oxygen and other gases.

Subcategories

- 0 General classification
- 9 Other pulmonary function

**47X Audiology**

Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Subcategories

- 0 General classification
- 1 Diagnosis
- 2 Treatment
- 9 Other audiology

**48X Cardiology**

Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress tests.

Subcategories

- 0 General classification
- 1 Cardiac cath lab
- 2 Stress test
- 9 Other cardiology

**49X Ambulatory Surgical Care**

Charges for ambulatory surgery not covered by other categories.

Subcategories

- 0 General classification
- 9 Other ambulatory surgical care



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**50X Outpatient Services**

Outpatient charges for services rendered to an outpatient admitted as an inpatient before midnight of the day following the date of service.

Subcategories

- 0 General classification
- 9 Other outpatient services

**51X Clinic**

Clinic (nonemergency/scheduled outpatient visit) charges for providing diagnostic, preventive curative, rehabilitative, and education services on a scheduled basis to ambulatory patients.

Subcategories

- 0 General classification
- 1 Chronic pain center
- 2 Dental clinic
- 3 Psychiatric clinic
- 4 OB-GYN clinic
- 5 Pediatric clinic
- 9 Other clinic

**52X Free-Standing Clinic**

Subcategories

- 0 General classification
- 1 Rural health – clinic
- 2 Rural health – home
- 3 Family practice
- 9 Other free-standing clinic

**53X Osteopathic Services**

Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.

Subcategories

- 0 General classification
- 1 Osteopathic therapy
- 9 Other osteopathic services



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**54X Ambulance**

Charges for ambulance service, usually on an unscheduled basis to the ill and injured requiring immediate medical attention.

**Note:** Ambulance is payable on the UB-92 form **only** in conjunction with inpatient admissions. Other ambulance charges must be submitted on the ambulance claim form. Documentation of medical necessity must be provided for ambulance transport. The diagnosis/documentation must reflect that the patient was nonambulatory and the trip was to the nearest adequate facility.

Subcategories

- 0 General classification
- 1 Supplies
- 2 Medical transport
- 3 Heart mobile
- 4 Oxygen
- 5 Air ambulance
- 6 Neonatal ambulance services
- 7 Pharmacy
- 8 Telephone transmission EKG
- 9 Other ambulance

**55X Skilled Nursing (home health agency only)**

Charges for nursing services that must be provided under the direct supervision of a licensed nurse ensuring the safety of the patient and achieving the medically desired result.

Subcategories

- 0 General classification
- 1 Visit charge
- 2 Hourly charge
- 9 Other skilled nursing



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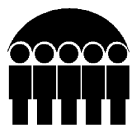
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- |  |  |  |
|--|--|--|
|  |  | <p><b>56X Medical Social Services (home health agency only)</b><br/>Charges for services such as counseling patients, interviewing and interpreting problems of social situations provided to patients on any basis.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none"><li>0 General classification</li><li>1 Visit charge</li><li>2 Hourly charge</li><li>9 Other medical social services</li></ul> <p><b>57X Home Health Aide (home health agency only)</b><br/>Charges made by a home health agency for personnel primarily responsible for the personal care of the patient.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none"><li>0 General classification</li><li>1 Visit charge</li><li>2 Hourly charge</li><li>9 Other home health aide services</li></ul> <p><b>61X MRI</b><br/>Charges for Magnetic Resonance Imaging of the brain and other body parts.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none"><li>0 General classification</li><li>1 Brain (including brainstem)</li><li>2 Spinal cord (including spine)</li><li>9 Other MRI</li></ul> <p><b>62X Medical/Surgical Supplies (extension of 27X)</b><br/>Charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcode 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Subcode 2 is for providers that cannot bill supplies used for other diagnostic procedures.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none"><li>1 Supplies incident to radiology</li><li>2 Supplies incident to other diagnostic services</li></ul> |
|--|--|--|



**63X Drugs Requiring Specific Identification**

Charges for drugs and biologicals requiring specific identification as required by the payer. If HCPCS is used to describe the drug, enter the HCPCS code in UB-92 form field number 44.

Subcategories

- 0 General classification
- 1 Single source drug
- 2 Multiple source drug
- 3 Restrictive prescription
- 4 Erythropoietin (EPO), less than 10,000 units
- 5 Erythropoietin (EPO), 10,000 or more units
- 6 Drugs requiring detailed coding

**64X Home IV Therapy Services**

Charges for intravenous drug therapy services performed in the patient's residence. For home IV providers the HCPCS code must be entered for all equipment and all types of covered therapy.

Subcategories

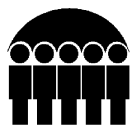
- 0 General classification
- 1 Nonroutine nursing, central line
- 2 IV site care, central line
- 3 IV site/change, peripheral line
- 4 Nonroutine nursing, peripheral line
- 5 Training patient/caregiver, central line
- 6 Training, disabled patient, central line
- 7 Training, patient/caregiver, peripheral line
- 8 Training, disabled patient, peripheral line
- 9 Other IV therapy services

**65X Hospice Services (hospice only)**

Charges for hospice care services for a terminally ill patient if he or she elects these services in lieu of other services for the terminal condition.

Subcategories

- 1 Routine home care
- 2 Continuous home care (hourly)
- 5 Inpatient respite care
- 6 General inpatient care
- 8 Care in an ICF or SNF



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**70X Cast Room**

Charges for services related to the application, maintenance, and removal of casts.

Subcategories

- 0 General classification
- 9 Other cast room

**71X Recovery Room**

Subcategories

- 0 General classification
- 9 Other recovery room

**72X Labor Room/Delivery**

Charges for labor and delivery room services provided by specially trained nursing personnel to patients. This includes prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if performed in the delivery suite.

Subcategories

- 0 General classification
- 1 Labor
- 2 Delivery
- 3 Circumcision
- 4 Birthing center
- 9 Other labor room/delivery

**73X EKG/ECG (electro-cardiogram)**

Charges for the operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiography for the diagnosis of heart ailments.

Subcategories

- 0 General classification
- 1 Holter monitor
- 2 Telemetry
- 9 Other EKG/ECG



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**74X EEG (electro-encephalogram)**

Charges for the operation of specialized equipment measuring impulse frequencies and differences in electrical potential in various brain areas to obtain data used in diagnosing brain disorders.

Subcategories

- 0 General classification
- 9 Other EEG

**75X Gastro-Intestinal Services**

Procedure room charges for endoscopic procedures not performed in the operating room.

Subcategories

- 0 General classification
- 9 Other gastro-intestinal

**76X Treatment or Observation Room**

Charges for the use of a treatment room or for the room charge associated with outpatient observation services. HCPCS code W9220 must be used with these codes (one unit per hour) on outpatient claims.

Subcategories

- 0 General classification
- 1 Treatment room
- 2 Observation room
- 9 Other treatment/observation room

**79X Lithotripsy**

Charges for the use of lithotripsy in the treatment of kidney stones.

Subcategories

- 0 General classification
- 9 Other lithotripsy



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**80X      Inpatient Renal Dialysis**

A waste removal process performed in an inpatient setting using an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Subcategories

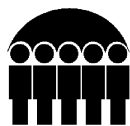
- 0      General classification
- 1      Inpatient hemodialysis
- 2      Inpatient peritoneal (nonCAPD)
- 3      Inpatient continuous ambulatory peritoneal dialysis
- 4      Inpatient continuous cycling peritoneal dialysis (CCPD)
- 9      Other inpatient dialysis

**81X      Organ Acquisition (see 89X)**

The acquisition of a kidney, liver or heart for transplant use. (All other human organs fall under category 89X.)

Subcategories

- 0      General classification
- 1      Living donor – kidney
- 2      Cadaver donor – kidney
- 3      Unknown donor – kidney
- 4      Other kidney acquisition
- 5      Cadaver donor – heart
- 6      Other heart acquisition
- 7      Donor – liver
- 9      Other organ acquisition



**82X Hemodialysis – Outpatient or Home**

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Subcategories

- 0 General classification
- 1 Hemodialysis/composite or other rate
- 2 Home supplies
- 3 Home equipment
- 4 Maintenance/100%
- 5 Support services
- 9 Other outpatient hemodialysis

**83X Peritoneal Dialysis – Outpatient or Home**

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategories

- 0 General classification
- 1 Peritoneal/composite or other rate
- 2 Home supplies
- 3 Home equipment
- 4 Maintenance/100%
- 5 Support services
- 9 Other outpatient peritoneal dialysis

**84X Continuous Ambulatory Peritoneal Dialysis (CCPD) – Outpatient or Home**

A continuous dialysis process performed in an outpatient or home setting using the patient peritoneal membrane as a dialyzer.

Subcategories

- 0 General classification
- 1 CAPD/composite or other rate
- 2 Home supplies
- 3 Home equipment
- 4 Maintenance/100%
- 5 Support services
- 9 Other outpatient CAPD



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**85X Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient or Home**  
A continuous dialysis process performed in an outpatient or home setting using a machine to make automatic changes at night.

Subcategories

- 0 General classification
- 1 CCPD/composite or other rate
- 2 Home supplies
- 3 Home equipment
- 4 Maintenance/100%
- 5 Support services
- 9 Other outpatient CCPD

**88X Miscellaneous Dialysis**  
Charges for dialysis services not identified elsewhere.

Subcategories

- 0 General classification
- 1 Ultrafiltration
- 2 Home dialysis aid visit
- 9 Miscellaneous dialysis other

**89X Other Donor Bank (extension of 81X)**  
Charges for the acquisition, storage, and preservation of all human organs (excluding kidneys, livers, and hearts – see 81X).

Subcategories

- 0 General classification
- 1 Bone
- 2 Organ (other than kidney)
- 3 Skin
- 9 Other donor bank



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**92X      Other Diagnostic Services**

Subcategories

- 0    General classification
- 1    Peripheral vascular lab
- 2    Electromyelogram
- 3    Pap smear
- 4    Allergy test
- 5    Pregnancy test
- 9    Other diagnostic services

**94X      Other Therapeutic Services**

Charges for other therapeutic services not otherwise categorized.

Subcategories

- 0    General classification
- 1    Recreational therapy
- 2    Education/training
- 3    Cardiac rehabilitation
- 4    Drug rehabilitation
- 5    Alcohol rehabilitation
- 6    Complex medical equipment – routine
- 7    Complex medical equipment – ancillary
- 9    Other therapeutic services

**99X      Patient Convenience Items**

Charges for items generally considered by the third party payers to be strictly convenience items, and, therefore, are not covered.

Subcategories

- 0    General classification
- 1    Cafeteria/guest tray
- 2    Private linen service
- 3    Telephone/telegraph
- 4    TV/radio
- 5    Nonpatient room rentals
- 6    Late discharge charge
- 7    Admission kits
- 8    Beauty shop/barber
- 9    Other patient convenience items



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43.	REVENUE DESCRIPTION	<b>OPTIONAL</b> – Enter a description of each revenue code billed.
44.	HCPCS/CPT/ RATES	<p><b>CONDITIONAL*</b> –</p> <p><u>Outpatient Hospital</u> – Enter the HCPCS/CPT code for each service billed, assigning a procedure, ancillary or medical APG.</p> <p><u>Inpatient SNF</u> – Enter the HCPCS code W0511 for ventilator dependent patients, otherwise leave blank.</p> <p><u>Home Health Agencies</u> – Enter the appropriate HCPCS code from the prior authorization when billing for EPSDT related services.</p> <p><u>All Others</u> – Leave blank.</p>
45.	SERVICE DATE	<b>OPTIONAL</b> – Entry in this field is optional for outpatient and no entry required for all others.
46.	UNITS OF SERVICE	<p><b>REQUIRED</b> –</p> <p><u>Inpatient</u> – Enter the appropriate units of service for accommodation days.</p> <p><u>Outpatient</u> – Enter the appropriate units of service provided per CPT/revenue code. (Batch-bill APGs require one unit = 15 minutes of service time.)</p> <p><u>Home Health Agencies</u> – Enter the appropriate units for each service billed. A unit of service = a visit. Prior authorization private-duty nursing/personal care – one unit = an hour.</p>
47.	TOTAL CHARGES	<b>REQUIRED</b> – Enter the total charges for each code billed.
48.	NONCOVERED CHARGES	<b>REQUIRED</b> – Enter the noncovered charges for each applicable code.
49.	UNLABELED FIELD	<b>OPTIONAL</b> – No entry required.



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50. A. – C.	PAYER IDENTIFICATION	<b>REQUIRED</b> – Enter the designation provided by the state Medicaid agency. Enter the name of each payer organization from which you might expect some payment for the bill.
51.	PROVIDER NUMBER	<b>REQUIRED</b> – Enter your seven-digit Medicaid provider number.
52. A. – C.	RELEASE OF INFORMATION CERTIFICATION INDICATOR	<b>OPTIONAL</b> – No entry required.
53. A. – C.	ASSIGNMENT OF BENEFITS...	<b>OPTIONAL</b> – No entry required.
54. A. – C.	PRIOR PAYMENTS	<b>REQUIRED</b> – If applicable, enter the amount paid by third-party payer.  Do not enter previous Medicaid payments.
55. A. – C.	ESTIMATED AMOUNT DUE	<b>OPTIONAL</b> – No entry required.
56. – 57.	UNLABELED FIELDS	<b>OPTIONAL</b> – No entry required.
58. A. – C.	INSURED'S NAME	<b>REQUIRED</b> – Enter the Medicaid recipient's last name, first name, and middle initial. Verify this information on the <i>Medical Assistance Eligibility Card</i> .
59. A. – C.	PATIENT'S RELATIONSHIP TO INSURED	<b>OPTIONAL</b> – No entry required.
60. A. – C.	CERTIFICATE/ SOCIAL SECURITY NUMBER/HEALTH INSURANCE CLAIM/IDENTI- FICATION	<b>REQUIRED*</b> – Enter the patient's Medicaid identification number found on the <i>Medical Assistance Eligibility Card</i> . It should consist of seven digits followed by a letter, i.e., 1234567A.



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61. A. – C.	INSURED GROUP NAME	<b>OPTIONAL*</b> – No entry required.
62.	INSURANCE GROUP NUMBER	<b>OPTIONAL*</b> – No entry required.
63.	TREATMENT AUTHORIZATION CODE	<b>CONDITIONAL</b> – If the patient is a MediPASS patient and the service is not an emergency, the physician authorization number must be shown here.
64. – 66.	EMPLOYMENT STATUS, EMPLOYER NAME AND LOCATION	<b>OPTIONAL*</b> – No entry required.
67.	PRINCIPAL DIAGNOSIS CODE	<b>REQUIRED</b> – Enter the ICD-9-CM code for the principal diagnosis.
68. – 75.	OTHER DIAGNOSIS CODES	<b>CONDITIONAL</b> – Enter the ICD-9-CM codes for diagnosis, other than principal, for the additional diagnosis.
76.	ADMITTING DIAGNOSIS	<b>OPTIONAL</b> – No entry required.
77.	“E” CODE	<b>OPTIONAL</b> – No entry required.
78.	DRG ASSIGNMENT	<b>OPTIONAL</b> – No entry required.
79.	PROCEDURE CODING METHOD USED	<b>OPTIONAL</b> – No entry required.
80.	PRINCIPAL PROCEDURE AND DATE	<b>CONDITIONAL</b> – For the principal surgical procedure, enter the ICD-9-CM procedure code and surgery date, when applicable.
81.	OTHER PROCEDURE CODES AND DATES	<b>CONDITIONAL</b> – For additional surgical procedures, enter the ICD-9-CM procedure codes and dates.



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82.	ATTENDING PHYSICIAN ID	<p><b>REQUIRED</b> –</p> <p><u>Inpatient Hospital, SNF, Rehab Agency, Home Health Agency, and PMIC</u> – Enter the UPIN or seven-digit Iowa Medicaid provider number for the treating physician. The last name, first initial, and discipline are also needed. The treating physician has primary responsibility for the patient's care from the start of hospitalization.</p> <p><u>Outpatient</u> – Enter the UPIN or seven-digit Iowa Medicaid provider number of the physician referring the patient to the hospital. This area should not be completed if the primary physician did not give the referral. On outpatient billings, do not show treating physician information in this area.</p> <p><b>Note:</b> For lock-in patients, enter the seven-digit Iowa Medicaid provider number of the lock-in physician or clinic in place of the above.</p>
83.	OTHER PHYSICIAN ID	<p><b>OPTIONAL</b> – Enter the UPIN number of physician performing the principal procedure, if applicable. If a UPIN number is unavailable, enter the physician's seven-digit Iowa Medicaid provider number. The last name, first initial, and discipline are also needed.</p>
84.	REMARKS	<p><b>OPTIONAL</b> – No entry required.</p>
85.	PROVIDER REPRESENTATIVE SIGNATURE	<p><b>REQUIRED</b> – The signature of an authorized representative must be shown.</p> <p>If the signature consists of computer-generated block letters, the signature must be initialed. A signature stamp may be used.</p>
86.	DATE BILL SUBMITTED	<p><b>REQUIRED</b> – Enter the original claim submission date. For resubmissions, be sure to indicate the original submission date, not the date of resubmission.</p>
<b>BACK OF FORM</b>	<b>NOTE</b>	<p><b>REQUIRED</b> – The back of the claim form must be intact on every claim form submitted.</p>

1

2

3 PATIENT CONTROL NO.

4 TYPE  
01 001

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD  
FROM THROUGH

7 COVD.

8 N.C.D.

9 C.I.D.

10 L.R.D.

11

12 PATIENT NAME

13 PATIENT ADDRESS

14 BIRTHDATE

15 SEX

16 MS

17 DATE

ADMISSION

18 HR

19 TYPE

20 SNO

21 D.H.R.

22 STAT

23 MEDICAL RECORD NO.

CONDITION CODES

31

32 CODE

OCCURRENCE DATE

33 CODE

OCCURRENCE DATE

34 CODE

OCCURRENCE DATE

35 CODE

OCCURRENCE DATE

36 CODE

OCCURRENCE DATE

OCCURRENCE SPAN

FROM THROUGH

37

A

B

C

38 CODE

VALUE CODES

AMOUNT

39 CODE

VALUE CODES

AMOUNT

40 CODE

VALUE CODES

AMOUNT

42 REV. CD.

43 DESCRIPTION

44 HCPCS / RATES

45 SERV. DATE

46 SERV. UNITS

47 TOTAL CHARGES

48 NON-COVERED CHARGES

49

50 PAYER

51 PROVIDER NO.

52 REL

53 AGG

54 PRIOR PAYMENTS

55 EST. AMOUNT DUE

56

**DUE FROM PATIENT**

58 INSURED'S NAME

59 P.REL.

60 CERT. - SSN - HIC - ID NO.

61 GROUP NAME

62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES

64 ESC

65 EMPLOYER NAME

66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.

68 CODE

69 CODE

70 CODE

71 CODE

72 CODE

73 CODE

74 CODE

75 CODE

76 CODE

77 CODE

78 CODE

79 ADM. DIAG. CD.

77 E-CODE

78

79 P.C.

80

PRINCIPAL PROCEDURE

CODE DATE

81

OTHER PROCEDURE

CODE DATE

OTHER PROCEDURE

CODE DATE

OTHER PROCEDURE

CODE DATE

OTHER PROCEDURE

CODE DATE

OTHER PROCEDURE

CODE DATE

OTHER PROCEDURE

CODE DATE

84 REMARKS

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID

OTHER PHYS. ID

85 PROVIDER REPRESENTATIVE

86 DATE

X

## UNIFORM BILL:

NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND OR STATE LAW.

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Christian Science Sanatoriums, verifications and if necessary re-verifications of the patient's need for sanatorium services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.
6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare purposes:

if the patient has indicated that other health insurance or a state medical assistance agency will pay part of his medical expenses and he wants information about his claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and other information to release to Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

## 8. For Medicaid purposes:

This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

## 9. For CHAMPUS purposes:

This is to certify that:

- (a) the information submitted as a part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;
- (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within the catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
- (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face of the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;
- (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;
- (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
- (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
- (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.
- (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

## ESTIMATED CONTRACT BENEFITS



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## **B. Facsimile of Claim Form, UB-92 (front and back)**

(See the preceding pages.)

## **C. Claim Attachment Control, Form 470-3969**

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- ◆ Staple the additional information to form 470-3969, *Claim Attachment Control*.  
(See the page following the claim form for an example of this form.)
- ◆ Complete the “attachment control number” with the same number submitted on the electronic claim. ACS will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- ◆ Do not attach a paper claim.
- ◆ Mail the *Claim Attachment Control* with attachments to:

ACS State Healthcare  
P.O. Box 14422  
Des Moines, IA 50306-3422

Once ACS receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

Iowa Medicaid Program

**Claim Attachment Control**

Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this form. The “Attachment Control Number” submitted on this form must be the same “attachment control number” submitted on the electronic claim. Otherwise the electronic claim and paper attachment cannot be matched up.

**Attachment Control Number**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**Provider Name** \_\_\_\_\_

**Pay-to-Provider Number**

--	--	--	--	--	--	--

**Recipient Name** \_\_\_\_\_

**Recipient State ID Number**

--	--	--	--	--	--	--	--

**Date of Service**            /        /       


**Type of Document**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**RETURN THIS DOCUMENT WITH ATTACHMENTS TO:**  
**ACS State Healthcare**  
**P.O. Box 14422**  
**Des Moines, IA 50306-3422**

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### III. REMITTANCE ADVICE AND EXPLANATION

#### A. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims. PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.



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of  
Human  
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT  
HOME HEALTH SERVICES

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F - 44b

DATE

July 2, 2003

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal agent with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

## **B. Facsimile of Remittance Advice**

(See the following page.)

10: [REDACTED] 1. R.A. NO.: 0000026 2. 3. DATE PAID: 05/19/97 PROVIDER NUMBER: [REDACTED] 4. PAGE: 5. 3

\*\*\*\* PATIENT NAME \*\*\*\* RECIP ID TRANS-CONTROL-NUMBER BILLED OTHER NON COV ALLOWED PAID BY MEDICAL  
LINE SVC-DATE PROC APG UNITS AMT, SOURCES CHARGES CHARGE MCAID REC. NO. S EOB EOB

\* 6. CLAIM TYPE: OUTPATIENT

\* 7. CLAIM PAID

ORIGINAL CLAIMS:

1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	18.	19.	20.	21.	22.	23.	24.	25.	26.	27.	28.	29.	30.	31.	32.	33.
5.	[REDACTED]	70220	351	1	81.00	0.00	0.00	58.60	APG	[REDACTED]	0.00	0.00	101.04	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
6.	4-96339-00-550-0899-00	212.45																														
7.	FROM 11/18/96 TO 11/18/96																															
8.	MED APG: 633																															
9.	01 11/18/96 250	2	16.45																													
10.	02 11/18/96 73510	1	81.00																													
11.	03 11/18/96 99284	1	115.00																													
12.	4-96340-00-55	12.00																														
13.	FROM 11/20/96 TO 11/20/96																															
14.	MED APG:																															
15.	01 11/20/96 W9281	1	12.00																													
16.	02 11/20/96																															
17.	03 11/20/96																															
18.	4-96346-00-553-0487-00	131.90																														
19.	FROM 12/03/96 TO 12/03/96																															
20.	MED APG:																															
21.	01 12/03/96 80019	1	72.40																													
22.	02 12/03/96 84478	1	20.00																													
23.	03 12/03/96 84436	1	14.60																													
24.	04 12/03/96 85027	1	18.40																													
25.	05 12/03/96 00001	1	6.50																													
26.																																
27.																																
28.																																
29.																																
30.																																
31.																																
32.																																
33.																																


REMITTANCE TOTALS

34.	NUMBER OF CLAIMS	1	-----	131.90	46.03
PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	-----	0.00	0.00
AMOUNT OF CHECK:					46.03

----- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

35. 900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

Page 46 was intentionally left blank.

 <b>Iowa Department of Human Services</b>	CHAPTER SUBJECT:  BILLING AND PAYMENT  HOME HEALTH SERVICES	CHAPTER      PAGE
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### C. Inpatient Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2. *Remittance Advice* number.
3. Date claim paid.
4. Billing provider's Medicaid (Title XIX) number.
5. *Remittance Advice* page number.
6. Type of claim used to bill Medicaid.
7. Status of following claims:
  - ◆ **Paid** – claims for which reimbursement is being made.
  - ◆ **Denied** – claims for which no reimbursement is being made.
  - ◆ **Suspended** – claims in process. These claims have not yet been paid or denied.
8. Recipient's last and first name.
9. Recipient's Medicaid (Title XIX) number.
10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.
11. Coverage dates as they appear on the claim.
12. DRG code.
13. Total number of covered days.
14. Total charges submitted by provider.
15. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.



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16. Total amount of Medicaid reimbursement as allowed for this claim.
17. Total noncovered charges as they appear on claim.
18. Explanation of benefits (EOB) code as it applies to entire claim. This code is for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for EOB code explanations.
19. Medical record number as assigned by provider; 10 characters are printable.
20. Difference between submitted charge and reimbursement amount.
21. Adjusted claims and reason codes. Codes are explained at the end of the *Remittance Advice*.
22. Difference in submitted charge and reimbursement amount resulting in a credit to Medicaid.
23. Remittance totals (found at the end of the *Remittance Advice*):
  - ◆ Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid.
  - ◆ Number of paid adjusted claims, amount billed by provider, and amount allowed and reimbursed by Medicaid.
  - ◆ Number of denied original claims and amount billed by provider.
  - ◆ Number of denied adjusted claims and amount billed by provider.
  - ◆ Number of pended claims (in process) and amount billed by provider.
  - ◆ Amount of check.
24. Description of individual adjustment reason codes.
25. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.



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#### IV. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records. Send these to:

ACS, Attn: Provider Inquiry  
PO Box 14422  
Des Moines, Iowa 50306-3422


To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- ◆ A paid claim amount needs to be changed, or
- ◆ Money needs to be credited back, or
- ◆ An entire *Remittance Advice* should be canceled.

Send this form to:

ACS, Attn: Credits and Adjustments  
PO Box 14422  
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

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**A. Facsimile of Provider Inquiry, 470-3744**

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

**B. Facsimile of Credit/Adjustment Request, 470-0040**

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program

**PROVIDER INQUIRY**

Attach supporting documentation. Check applicable boxes: ☐ Claim copy ☐ Remittance copy  
☐ Other pertinent information for possible claim reprocessing.

1. 17-DIGIT TCN																	
2. NATURE OF INQUIRY																	
I N Q U I R Y  A	(Please do not write below this line)																
	<b>FISCAL AGENT RESPONSE</b>																

1. 17-DIGIT TCN																	
2. NATURE OF INQUIRY																	
I N Q U I R Y  B	(Please do not write below this line)																
	<b>FISCAL AGENT RESPONSE</b>																

Provider Signature/Date:		MAIL TO: ACS P. O. BOX 14422 DES MOINES IA 50306-3422		ACS Signature/Date:	
Provider Please Complete:		7-digit Medicaid Provider ID# _____ Telephone _____		(FOR ACS USE ONLY) PR Inquiry Log # _____ Received Date Stamp:	
Name Street City, St Zip		<div style="border: 1px dashed black; height: 60px; width: 100%;"></div>			

Page 52 was intentionally left blank.

## Iowa Medicaid Program

**CREDIT/ADJUSTMENT REQUEST**

Do **not** use this form if your claim was denied. Resubmit denied claims.

**SECTION A: Check the most appropriate action and complete steps for that request.**☐ **CLAIM ADJUSTMENT**

- ◆ Attach a complete copy of claim.  
(If electronic, use next step.)
- ◆ Attach a copy of the Remittance Advice with corrections in **red ink**.
- ◆ Complete Sections B and C.

☐ **CLAIM CREDIT**

- ◆ Attach a copy of the Remittance Advice.
- ◆ Complete Sections B and C.

☐ **CANCELLATION OF ENTIRE REMITTANCE ADVICE**

- ◆ Use only if all claims on Remittance Advice are incorrect. This option is rarely used.
- ◆ Attach the check and Remittance Advice.
- ◆ Skip Section B. Complete Section C.

**SECTION B:**

1. 17-digit TCN

2. Pay-to Provider #:

4. 8-character Iowa Medicaid Recipient ID:  
(e.g., 1234567A)

3. Provider Name and Address:

5. Reason for Adjustment or Credit Request:

**SECTION C:**

Provider/Representative Signature:

Date:

**FISCAL AGENT USE ONLY: REMARKS/STATUS**

Return All Requests To:

ACS  
PO Box 14422  
Des Moines, IA 50306-3422

March 7, 1996

For Human Services Use Only

General Letter No. 8-A-AP(II)-583

Subject: Employees' Manual, Title VIII, Chapter A, Appendix, Part Two

HOME HEALTH SERVICES MANUAL TRANSMITTAL NO. 96-1

Subject: ***Home Health Services Manual***, Table of Contents, page 5, revised; and Chapter E, *Coverage and Limitations*, page 42, revised.

This release adds the new CPT codes for Hepatitis B vaccine effective January 1, 1996. The current CPT code of 90731 will be phased out March 31, 1996.

Date Effective

March 1, 1996

Material Superseded

Remove from the ***Home Health Services Manual*** Table of Contents, page 5, dated August 1, 1995, and Chapter E, page 42, dated August 2, 1995 and destroy them.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES  
Charles M. Palmer, Director

Donald W. Herman, Administrator  
DIVISION OF MEDICAL SERVICES

June 6, 1997

For Human Services Use Only

General Letter No. 8-AP-28

Subject: Employees' Manual, Title 8, Medicaid, Appendix

**HOME HEALTH SERVICES MANUAL TRANSMITTAL NO. 97-1**

Subject: *Home Health Services* Manual, Chapter E, *Coverage and Limitations*, page 42, revised.

This release adds varicella to list of VFC vaccines.

**Date Effective**

May 1, 1997

**Material Superseded**

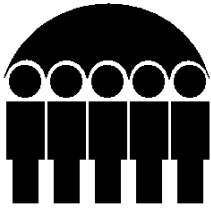
Remove from the Home Health Services Manual Chapter E, and destroy page 42, dated March 1, 1996.

**Additional Information**

If any portion of this manual is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES  
Charles M. Palmer, Director

Donald W. Herman, Administrator  
DIVISION OF MEDICAL SERVICES



Iowa Department of Human Services

For Human Services use only:

**General Letter No. 8-AP-38**

Employees' Manual, Title 8  
Medicaid Appendix

January 5, 1998

**HOME HEALTH SERVICES MANUAL TRANSMITTAL NO. 98-1**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Home Health Services Manual*, Chapter E, *Coverage and Limitations*, pages 36, 38, 41, and 42, revised.

This release changes information related to the fiscal agent, clarifies current policy that medical transportation is not a home health benefit, and adds a second code for polio.

**Date Effective**

Upon receipt.

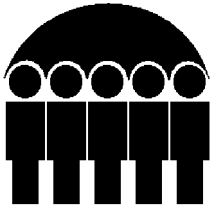
**Material Superseded**

Remove the following pages from *Home Health Services Manual* and destroy them:

<u>Page</u>	<u>Date</u>
<b>Chapter E</b>	
36, 38	April 1, 1994
41	August 1, 1995
42	May 1, 1997

**Additional Information**

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

**General Letter No. 8-AP-71**

Employees' Manual, Title 8  
Medicaid Appendix

June 8, 1998

**HOME HEALTH SERVICES MANUAL TRANSMITTAL NO. 98-2**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Home Health Services Manual*, Table of Contents (page 5), revised; Chapter E, *Coverage and Limitations*, pages 1, 3, 42, and 43, revised; page 44, new; Chapter F, *Billing and Payment*, pages 1 through 26, revised; and pages 27 through 48, new.

Chapter E is revised to clarify current policy that homework assistance is not a home health benefit and that the treatment plan timeframe is 62 days and to add a definition for technology dependent children.

Chapter F is revised to update billing and payment instructions.

**Date Effective**

Chapter E revisions are effective July 1, 1998.

Chapter F revisions are effective upon receipt.

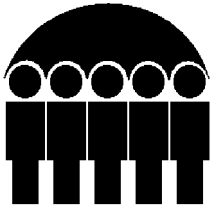
**Material Superseded**

Remove the following pages from *Home Health Services Manual* and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 5)	March 1, 1996
<b>Chapter E</b>	
1, 3	April 1, 1994
42	January 1, 1998
43	August 1, 1995
<b>Chapter F</b>	
1	April 1, 1994
2	7/86
3-6	April 1, 1994
7, 8	Undated
9-21	April 1, 1994
22	Undated
23-25	01/22/94
26	April 1, 1994

**Additional Information**

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

**General Letter No. 8-AP-77**

Employees' Manual, Title 8  
Medicaid Appendix

July 27, 1998

**HOME HEALTH SERVICES MANUAL TRANSMITTAL NO. 98-3**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Home Health Services Manual*, Chapter F, *Billing and Payment*, pages 11, 15, 16, 24, and 25, revised, and page 16a, new.

This letter transmits corrections to the billing and payment instructions as follows:

- ◆ Typographical errors are corrected on pages 11 and 24.
- ◆ Insurance-Related codes on page 15 are corrected.
- ◆ Subcategory codes which were inadvertently deleted are replaced on pages 16, 16a, and 25.

**Date Effective**

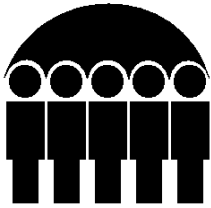
Upon receipt.

**Material Superseded**

Remove pages 11, 15, 16, 24, and 25, all dated July 1, 1998, from the *Home Health Services Manual* and destroy them.

**Additional Information**

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

**General Letter No. 8-AP-107**

Employees' Manual, Title 8  
Medicaid Appendix

April 9, 1999

**HOME HEALTH SERVICES MANUAL TRANSMITTAL NO. 99-1**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Home Health Services Manual*, Chapter E, *Coverage and Limitations*, page 42,  
revised.

This revision adds the codes for rotavirus vaccine.

**Date Effective**

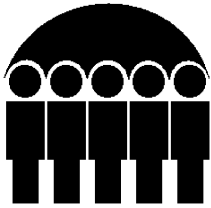
Upon receipt.

**Material Superseded**

Remove from *Home Health Services Manual*, page 42, dated July 1, 1998, and destroy it.

**Additional Information**

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services Use Only:

**General Letter No. 8-AP-149**  
Employees' Manual, Title 8  
Medicaid Appendix

August 7, 2000

**HOME HEALTH SERVICES MANUAL TRANSMITTAL NO. 00-1**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Home Health Services Manual*, Table of Contents, pages 4 and 5, revised; Table of Contents, page 6, new; Chapter E, *Coverage and Limitations*, pages 1 through 44, revised; and pages 45 through 48, new; and Chapter F, *Billing and Payment*, pages 49 through 53, new.

Changes in home health services, implemented July 1, 2000, were made possible due to emergency rule making authority and appropriations by the Legislature. The Human Services Council Administrative adopted rules regarding these changes June 8, 2000, for implementation July 1, 2000. The changes are summarized as follows.

**Intermittent Guidelines**

The definitions of “skilled nursing” and “home health aide services” that meet the intermittent guidelines for payment under Medicaid are being expanded. When ordered by a physician and included in the plan of care, the following services will be considered to meet the intermittent guidelines:

- ◆ Skilled nursing visits provided five days per week.
- ◆ Daily skilled nursing visits or multiple daily visits for wound care or insulin injections.
- ◆ Home health aide services provided for four to seven days per week which do not exceed 28 hours of home health aide services per week.

**Services Under the EPSDT Authority**

Private duty nursing is being expanded to cover medical assessment and medical monitoring which requires the use of nursing skills. All time is covered if there is at least one nursing intervention per day.

If there is not nursing intervention at least one time per day and the physician has ordered assessment and monitoring for specific health issues for the balance of the day, the recipient's physician will be requested to provide an explanation of the ongoing need for nursing services.

Personal care services are being expanded to include cueing when related to personal care services such as bathing and eating. Cueing related to behavior management services will **not** be covered.

## **Billing Forms**

Forms 470-3744, *Provider Inquiry*, and 470-0040, *Credit/Adjustment Request*, are added to Chapter F for provider convenience.

## **Date Effective**

July 1, 2000

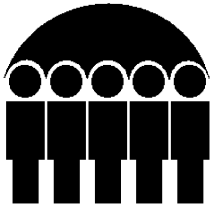
## **Material Superseded**

Remove the following pages from the *Home Health Services Manual* and destroy them:

<u>Page</u>	<u>Date</u>
Table of Contents (page 4)	April 1, 1994
Table of Contents (page 5)	July 1, 1998
<b>Chapter E</b> (all)	
1	July 1, 1998
2	April 1, 1994
3	July 1, 1998
4-35	April 1, 1994
36	July 1, 1997
37	April 1, 1994
38	July 1, 1997
39, 40	April 1, 1994
41	January 1, 1998
42	March 1, 1999
43, 44	July 1, 1998

## **Additional Information**

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

**General Letter No. 8-AP-204**

Employees' Manual, Title 8

Medicaid Appendix

February 28, 2003

## **HOME HEALTH SERVICES MANUAL TRANSMITTAL NO. 03-1**

ISSUED BY: Bureau of Long-Term Care

SUBJECT: ***HOME HEALTH SERVICES MANUAL***, Chapter E, *Coverage and Limitations*, pages 35 through 40, 43, 45, and 48, revised; Chapter F, *Billing and Payment*, pages 49, 51, and 53, revised.

### **Summary**

Chapter E is updated to include a section addressing administrative simplification, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Administrative simplification includes use of standard code sets, such as HCPCS codes, and elimination of local codes for Medicaid services.

This release eliminates the local codes for private duty nursing and personal care. Bill using the procedure code approved on the prior authorization.

#### **Crosswalk Between Local Codes and New Codes**

Local Code	New Code
W0520	S9123
W0521	S9123
W0522	S9124
W0523	S9124
W0524	S9122

**Note:** Continue to use the local "W" codes for prior authorizations that have already been approved.

Both chapters are updated to change the name of the fiscal agent from "Consultec" to "ACS" and the name "Merit Behavioral Care" to "Iowa Plan contractor."

### **Date Effective**

April 1, 2003

**Note:** Effective for prior authorization requests for dates of service on or after April 1, 2003, you must use the new codes on requests and subsequent claims.

## **Material Superseded**

Remove the following pages from the *HOME HEALTH SERVICES MANUAL* and destroy them:

<u>Page</u>	<u>Date</u>
<b>Chapter E</b>	
35-40, 43, 45, 48	July 1, 2000
<b>Chapter F</b>	
49	July 1, 2000
51, 53	4/00

## **Additional Information**

The updated provider manual containing the revised pages can be found at:

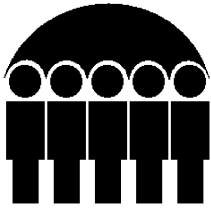
**[www.dhs.state.ia.us/policyanalysis](http://www.dhs.state.ia.us/policyanalysis)**

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS  
Manual Transmittal Requests  
PO Box 14422  
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

**General Letter No. 8-AP-223**

Employees' Manual, Title 8

Medicaid Appendix

August 12, 2003

**HOME HEALTH SERVICES MANUAL TRANSMITTAL NO. 03-2**

ISSUED BY: Bureau of Long-Term Care

SUBJECT: ***HOME HEALTH SERVICES MANUAL***, Table of Contents, page 5, revised; Chapter E, *Coverage and Limitations*, pages 12, and 13, revised; Chapter F, *Billing and Payment*, pages 43, and 44, revised; and pages 6a, 6b, 44a, 44b, 51, 52, and 53, new.

**Summary**

Chapter E is updated to reflect changes in the Vaccines for Children (VFC) program.

Chapter F is revised to:

- ◆ Add instructions for forms 470-3969, *Claim Attachment Control*, and 470-3970, *Prior Authorization Attachment Control*, used to submit paper attachments for an electronic claim or prior authorization request.
- ◆ Add form 470-3744, *Provider Inquiry*. Complete this form if you wish to inquire about a denied claim or if claim payment was not as expected.
- ◆ Add form 470-0040, *Credit/Adjustment Request*. Complete this form to notify ACS that.
  - A paid claim amount needs to be changed; or
  - Funds need to be credited back; or
  - An entire *Remittance Advice* should be canceled.

Both chapters have been revised to replace references to “Consultec” with “ACS.”

**Date Effective**

July 1, 2003

## **Material Superseded**

Remove the following pages from the ***HOME HEALTH SERVICES MANUAL*** and destroy them:

<u>Page</u>	<u>Date</u>
Table of Contents (page 5)	July 1, 2000
<b>Chapter E</b> 12, 13	July 1, 2000
<b>Chapter F</b> 43, 44	July 1, 1998

## **Additional Information**

The updated provider manual containing the revised pages can be found at:

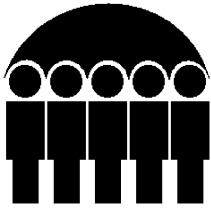
**[www.dhs.state.ia.us/policyanalysis](http://www.dhs.state.ia.us/policyanalysis)**

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS  
Manual Transmittal Requests  
PO Box 14422  
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:  
**General Letter No. 8-AP-234**  
Employees' Manual, Title 8  
Medicaid Appendix

September 30, 2003

## **HOME HEALTH SERVICES MANUAL TRANSMITTAL NO. 03-3**

ISSUED BY: Bureau of Long-Term Care

SUBJECT: ***HOME HEALTH SERVICES MANUAL***, Table of Contents, page 5, revised; Chapter E, *Coverage and Limitations*, page 13, revised; and Chapter F, *Billing and Payment*, page 44b, revised.

### **Summary**

Chapters E and F are updated to correct administration codes and headings.

### **Date Effective**

July 1, 2003

### **Material Superseded**

Remove the following page from the ***HOME HEALTH SERVICES MANUAL*** and destroy it:

<u>Page</u>	<u>Date</u>
Table of Contents (page 5)	July 1, 2003
<b>Chapter E</b>	
13	July 1, 2003
<b>Chapter F</b>	
44b	July 1, 2003

### **Additional Information**

The updated provider manual containing the revised pages can be found at:

**[www.dhs.state.ia.us/policyanalysis](http://www.dhs.state.ia.us/policyanalysis)**

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS  
Manual Transmittal Requests  
PO Box 14422  
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.